STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 000	Initial Comments Facility Reported Incident Investigation to Incident of 12/12/22/IL155253	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)3)6) 300.3210t) 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 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 resident to meet the total nursing and personal care needs of the resident. Section 300.1210 General Requirements for Nursing and Personal Care 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: 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) The facility shall ensure 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 300.3210 t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property. Based on interview, observation, and record review, the Facility failed to supervise and implement progressive interventions to prevent resident to resident physical abuse, and to address threats of suicide and self-injurious behaviors. This failure has the potential to affect all 142 residents living in the facility.to address threats of suicide and self-injurious behaviors for	S9999		

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S9999	Continued From page 2 1 of 3 residents (R2) reviewed for supervision in the sample of 11. This failure has resulted in R2 expressing suicidal ideations and self-injurious behavior resulting in recurrent emergency room evaluation and treatment. 2.) Based on interview and record review, the facility failed to provide behavioral health service for mental illness to maintain/improve resident's psychosocial well-being for 1 of 3 residents (R2) reviewed for behavioral health services for mental illness in the sample of 14. This resulted in R2 having ongoing behaviors of self-harm, suicidal ideations, impulsive and explosive verbal and physical aggression recurrent emergency room evaluation and treatments. Findings Include: 1. R2's Admission Record, dated 1/12/23, documents that R2 was admitted to the facility on 4/19/22. R2's Diagnosis include: Schizophrenia, Major Depressive Disorder, and Bipolar. R2's Illinois PASRR (Preadmission Screening and Resident) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property. Review Summary of Findings, dated 4/17/22, documents R2 has been diagnosed with an Intellectual Disability. R2's Electronic Medical Record under Weights/Vitals, documents that on 10/14/22, R2 was 72 inches tall, and on 1/11/23 R2's weight was 350 pounds.	S9999		

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S9999	Continued From page 3 R2's Care Plan, dated 12/5/22, documents "(R2) can become verbally and physical aggressive when he does not get his way." R2's Care Plan, dated 12/5/22, documents "(R2) has a history of self-harming as a form of attention seeking. (R2) uses a bell in place of a call light due to self-harming behaviors. 5/22/22 resident used a plastic knife to place superficial cuts on arms. 10/2/22 walked outside of the building over the weekend multiple times and had self-harming behavior. 12/4/22 (R2) was having homicidal thoughts against his roommate." It continues "(R2) is at high risk for elopement. He has a history of leaving home when he is upset. 12/5/22 (R2) ran out of the building Dr. (Doctor) wonder was announced immediately over the intercom and staff went out and immediately brought him back into the facility." R2's Minimum Data Set (MDS), dated 1/9/23, documents that R2's Brief Interview of Mental Status (BIMS) is 15, which means that R2 is cognitively intact. R2's MDS documents that he is independent for all of his (Activities of Daily Living (ADL's), including ambulation. R2's MDS, documents R2's Physical Behavioral symptoms directed towards others occurred one to three days. R2's Verbal Behavioral symptoms directed towards others occurred four to six days. R2 has Overall Presence of Behavioral Symptoms that put the resident at significant risk for physical illness or injury significantly interferes with resident's care and significantly interferes with resident's participation in activities or social interactions. R2's Behavioral Symptoms put others at significant risk of physical injury, significantly intrudes on the privacy or activity of others, and significantly disrupts care or living environment. R2's Wandering Behavior occurred	S9999		

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S9999	Continued From page 4 daily, places the resident at significant risk of getting to a potentially dangerous place and significantly intrudes on the privacy or activities of others. R2's Change in Behavior or Other Symptoms are worse than the prior assessment. R2 acknowledged feeling down, depressed, or hopeless, feeling bad about himself, or that he was a failure or have let himself or his family down. R2 denied thoughts that he would be better off dead, or of hurting himself in some way. R2's Care Plan Interventions regarding self-harming behavior, dated 4/21/22 documents "Document all episodes of suicidal ideations; provide experience/interactions that enhance self-esteem, sense of personal power; conduct appropriate interdisciplinary assessments upon admission. Review transfer forms, including screening material to determine any history of self-harm; and assess seriousness of suicidal ideation, noting behaviors such as gestures, threats giving away possessions R2's Nurse's Note, dated 4/24/22 at 3:37 PM, documents "Resident became verbally aggressive with another resident (R8), resident was asked to go down the hall to separate residents. Neither resident became physical with each other. This nurse (V21, Licensed Practical Nurse/ LPN) and other staff defused situation before resident began punching walls and throwing objects down the hall. Resident then eloped from facility with staff member right behind and was redirected back to the building by staff member. This nurse called (V19, Physician) and was given orders to send resident to (Regional Hospital). This nurse called residents guardian made aware. EMS (Emergency Medical Service) as well as three (Local Police Department) officers arrived and escorted resident out by	S9999		

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S9999	Continued From page 5 stretcher. Resident left A&O x3 (Alert and oriented times three). Resident had no bruising noted at the time." R2's Nurses Note, dated 4/24/22 at 6:50 PM by V21, LPN, documents "Resident returned from (Regional Hospital). Did not meet criteria to be admitted per ER (Emergency Room) staff. Resident returned with no new orders. Guardian (V4) notified of his returning." There is no documentation that 1:1 was implemented upon R2's return to the facility. There is nothing further documented on this day. R2's Nurse's Note, dated 4/25/22 at 12:32 PM, documents "This nurse (V21, LPN) notified resident exited building with 1:1 staff following behind him. This nurse went outside to meet resident and staff. This nurse was able to redirect resident back to the facility with difficulty. Resident was suicidal in the process of walking back to facility. Resident also stated he was homicidal and wanted to burn the building down after he leaves. Resident was placed in the administrator office while guardian was called and (Local Ambulance) and waiting for (Local Police Department) to arrive. Resident being homicidal to resident and staff. Order was given to send resident to (Regional Hospital). Resident guardian made aware." There was nothing further documented after arrival back to facility. R2's Nurses Note, dated 4/25/22 at 2:21 PM, documents "Resident was sent to ER per (V19, Physician) for aggressive behavior toward residents and staff, throwing objects down hall, eloped outside to parking lot, hitting and beating on staffs' cars in the parking lot, unable to redirect, (Local Ambulance) and police called to transfer resident to (Regional Hospital) for	S9999		

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S9999	Continued From page 6 evaluation and treat. Report given to ER at (Regional Hospital) prior to resident's arrival. POA (Power of Attorney) notified." (Documented by V9, LPN). No further documentation. There is no documentation in R2's medical record that any interventions were implemented after R2 was sent to hospital for suicidal ideations and homicidal allegations on 4/25/22 including addressing R2's need for increased supervision. R2's Care Plan was not revised after the 4/25/22 incident. R2's Nurses Note, dated 4/26/22 at 11:21 AM, documents "Resident came back into facility via stretcher. Resident went into (room #). Resident told staff he would slap someone. Resident became upset after phone call with family member. Resident threw phone down while in administrator's office. Hall monitor redirected resident to calm down because he would not be able to go into hallway while being aggressive. Resident threw himself against wall. (V19, Physician) was notified, gave order to send resident to (Regional Hospital) and Guardian was also notified. Police came to assist. Ambulance came as well. Resident was sent out via stretcher." There was nothing further documented after arrival back to facility regarding if R2 was receiving increased supervision from staff. There is no one-on-one documentation as they started on 5/6/22. R2's Care Plan, dated 12/5/22, documents "(R2) can become verbally and physically aggressive when he does not get his way." R2's Care Plan revised on 4/25/22 documented "4/25/22 Physical altercation (R2) threw a picture frame in the	S9999		

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hallway and hit another resident. 4/25/22 Verbal aggression in the evening time." R2's Care Plan Interventions, initiation date of 4/25/22, document the following: Encouraged to use phone in the privacy of his room; Resident was informed that it is unacceptable behavior to throw objects; Resident transferred to Hospital for evaluation and upon return from hospital, discussed with resident to contact his guardian about placement at a facility.

R2's Nurses Note, dated 4/27/22 at 9:59 AM, documents "Resident arrived to facility via EMS on stretcher."

R2's Nurses Noted, dated 4/27/22 at 10:37 AM, documents "(V19, Physician) made aware of arrival, NNO (No New Orders). Guardian (V4) made aware."

The Facility's Final IDPH (Illinois Department of Public Health) Incident and/or Abuse Notification, dated 4/25/22, documents "On 4/25/22 staff reported a physical altercation between (R2), a 30-year-old male resident with a diagnosis of Schizophrenia and (R8), a 53-year-old male resident with a diagnosis of Paranoid Schizophrenia. Staff reported (R2) threw a picture frame down the hallway causing it to make contact with (R8) who was sitting in hallway with no injury. Resident (R8) voiced no complaints of pain. Administrator initiated an investigation. Interviewable residents and staff were interviewed. Medical Records were reviewed for both residents including medication review."

R2's Nurse's Note, dated 4/28/22 at 1:22 PM, documents "Resident stated to this nurse he was having suicidal ideations and was going to start knocking M***** F****** out and he wanted to be

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S9999	Continued From page 8 sent out to the hospital. This nurse called DR., received order to send to (Regional Hospital), (Local Ambulance) arrived with (Local Police Department) for transfer to hospital. Resident calmly put himself onto stretcher, left facility, A/OX3 (alert and oriented times three), responding upon command, POA made aware." R2's Care Plan was not revised with progressive interventions to address R2's suicidal ideations and if R2 was receiving increased supervision after he was sent to the hospital on 4/28/22. On 1/18/23 at 3:10 PM, R8 stated "I remember when (R2) was down here with us. (R2) was very upset about something one day and hitting the walls and tearing things up. He took a picture frame off the wall and threw it down the hall and I happen to be hit by it. I believe my neighbor (R9) had an issue one day with (R2). You might want to talk to him." On 1/18/23 at 3:15 PM, R9 stated "When (R2) first came down here, he was being loud in the hall and when I asked him to quiet it down, he became verbally aggressive towards me and threatened to kill me. I told the staff and they sent him out to the hospital. I wasn't afraid of him until he threatened to kill me. Then I was afraid of him because I wasn't sure if he would follow through with it." R2's Nurse's Note, dated 5/2/22 at 9:47 PM, documents "Resident became verbally and aggressive. resident expressed he wanted a blanket and pillow sooner. Resident set off door alarm and walked away from door, resident knocked off covering to exit sign. This nurse tried to redirect resident. resident back verbally aggressive again. Resident expressed	S9999		

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self-harming thought. Resident was given the items he wants resident went back to room. This nurse gave resident a few minutes to get situated in room and calm down then this nurse entered the room to speak with resident. The resident appeared calmer, this nurse asked resident what was wrong. The resident stated he was mad he wanted the items, but he didn't know that the hall monitor had already went to get them items for him. This nurse asked resident if he still had self-harming thoughts. The resident stated no I'm not going to do anything to myself, I was just mad. This nurse proceeded to address behaviors with resident and let resident know that was the proper way to handle things, resident was educated on how to handle situations when he does not feel things are being handled correctly. Resident voiced understanding and stated I just was mad at the time. I'm okay now I'm just going to get some sleep. Thanks man. Resident will continue on frequent checks throughout the night. Psych (Psychiatric) DR. (Physician). made aware resident guardian."

R2's Care Plan was revised on 5/02/22 and documented verbal and physical aggression towards staff. R2's Care Plan Interventions, initiated on 5/2/22 documented "Encourage resident to allow staff time to retrieve items he is requesting."

R2's Nurse's Note, dated 5/4/22 at 8:08 PM, documents "(R2) sitting at nurse's station charging his cell phone, peer (R6) also at nurses' station yelling B* N****, peer (R6) directed focus to this nurse. (R2) being [sic] to voice to peer don't disrespect a woman, this nurse redirected (R2) voicing that he didn't need to intervene, peer then focused in on (R2) and being to propel self to (R2), peer (R6) being [sic] to swing in a

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slapping motion, (R2) being [sic] to punch peer. This nurse (V10, LPN) attempted to separate the two, while yelling for help. Another nurse came to help, that nurse was able to get (R2) in his room, 911 called. Other staff came to assist, peer (R6) continuously knocked hard on (R2) door. (V19, Physician) called gave orders to send to (Regional Hospital) ED (Emergency Department), police arrived, got peer (R6) to calm down and leave (R2's) door. No injuries noted, (R2) denies pain at this time. Guardian called after directed to after hours phone line, Representative took message on the events occurred and voiced that the on-call guardian will be made aware, EMS here Face Sheet, POLST (Physicians Orders for Life Sustaining Treatment) form and transfer sheet sent with resident. (Regional Hospital) ED called to give report. DON (Director of Nursing) made aware."

The Facility's Final IDPH Incident and/or Abuse Notification, dated 5/4/22, documents "On 5/4/22 an altercation occurred involving (R2), a 30-year-old male with a diagnosis of Bipolar, and (R6), a 50-year-old male with a diagnosis of Schizophrenia. (R2) was sitting at the nursing station talking with nurse while charging his phone. At the same time, (R6) wheeled up and started being verbally aggressive towards the nurse. It was reported that when (R6) became aggressive with the nurses, (R2) told him 'You shouldn't talk to women that way'. (R6) reacted to (R2) comment and became aggressive towards him, resulting in a physical altercation with both residents making contact with each other. Nursing assessed both residents. No injuries noted. The Administrator was notified. An investigation immediately began. Interviewable residents have been interviewed. Staff interviews have been completed. Medical record reviews

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S9999	Continued From page 11 which included medication reviews for both residents were completed." R2's Care Plan was reviewed on 5/4/22 and documented R2 was verbally aggressive with staff/peer. R2's Care Plan Intervention, initiation date of 5/4/22, documented "If resident becomes upset, give him time to calm down then re-approach, Staff to allow resident to vent feelings. Administer medications as per MD (Medical Doctor) orders. Notify MD if behaviors are worsening. Call resident guardian to see if he can assist in calming (R2). Staff to encourage resident to attend daily group therapy. If resident becomes aggressive attempt to remove resident from situation and assist him/her to a quiet place. Encourage resident to vent his/her feelings about situation. Remind resident that behavior is not acceptable. If resident refuses care, care giver should leave room and try again later. Separate residents as needed. Staff will ensure that each resident is safe." On 1/24/23 at 9:05 AM, V10, LPN, stated "I remember (R2) was sitting at the nurse's desk (5/4/22) when (R6) walked by and started saying things to (R2). That triggered (R2) which started a verbal argument which then turned into a physical altercation. I remember that (R2) was hitting (R6) and then they got separated and (R2) got sent to the hospital." R2's Nurse's Note, dated 5/9/22 at 9:46 AM, documents "A SAD (Seasonal Affective Disorder) assessment was conducted and completed on (R2) to determine if he is suicidal. (R2's) SAD scale score was 4. The score of 4 suggest that (R2) should continue to be closely monitored and any objects that he can use to harm himself should be removed from his room and	S9999		

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S9999	Continued From page 12 possession." There was no documentation in R2's medical record that based upon the SAD assessment the facility implemented any progressive interventions to address R2's self harming behaviors and suicidal ideations. R2's Nurse's Note, dated 5/15/22 at 1:22 PM, documents "(R2) got upset this afternoon because the kitchen wouldn't give him a banana. He talked to me about the matter, and he was told to give me some time to get to kitchen to find out what happen. (R2) did not allow this staff enough time to investigate what happen. He went back to the kitchen and attempted to make kitchen staff give him a banana. They refused, he became angry and exploded. This social worker had to escort (R2) back to his room whereas he made suicidal threats. He did eventually calm down. Incident recorded in his behavior tracking sheet." There was no documentation in R2's medical record the facility implemented any progressive intervention after R2's incident of expressing suicidal threats or implement any type of increased supervision to monitor for R2's safety on 5/15/22. R2's Care Plan was not revised with any progressive interventions at that time. On 1/12/23 at 2:23 PM, V6, Social Service Director, stated "(R2) is supposed to be attending groups, such as Life Skills, Anger Management, and Community Living, but (R2) will come into the meeting, become very vocal and disruptive, and leave within a few minutes of being there. Sometimes what we are doing for (R2) just doesn't work. Right now, the only thing we are	S9999		

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S9999	Continued From page 13 doing for him is one on one. (R2) knows that if he says something suicidal or homicidal, that we will send him out for an evaluation, so he gets out of the building. When he returns, he is put on a 72-hour one-on-one watch. It seems like as soon as his watch/evaluation period is done, he starts to act up again, especially when he doesn't get his way." R2's Nurse's Note, dated 5/24/22 at 5:53 PM, documents "This nurse (V10, LPN) in hallway passing dinner trays when (R2) brought dinner tray back to serving cart, peer (R6) seen (R2) and began to yell loudly YEAH as he propelled self toward (R2). this nurse attempted to move (R2) out of the way before peer (R6) could grab him, unsuccessful. Peer (R6) grabbed (R2) by the shirt and they both exchanged several punches to the face, staff intervened separating the two, as (R2) is walking to room peer (R6) broke free and being to propel self to (R2) again, (R2) turned around and grabbed a wet floor sign and began to hit peer (R6), the two separated again by staff. This nurse went to assess (R2), blood noted to his face, after cleaning area, blood coming from nose, instruct him to pinch nose and hold head down until bleeding stop. (Local Police Department) arrived, this nurse called (V19) at this time gave orders to send to (Local Hospital) to Evaluate and Treat. Guardian on call made aware. MOD (Manager on Duty) made aware." There was no documentation of any additional supervision such as 1:1. R2's Nurse's Note, dated 5/21/22 at 7:49 PM, documents "(R2) eloped out of the dining room exit door, alarms didn't sound. Hall monitor voiced that he attempted to go out of the smoke door on 100-hall redirected by staff to come back to 300-hall, as (R2) walked back to this side, he	S9999		

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exited out of the dining area door. Staff members saw (R2) from 100-hall exit door walking across the parking lot, while walking away from the building (R2) began to cut his right arm with a butter knife, staff followed him and redirected him back into the facility as he's walking back into the facility, he threw the knife. Once in the facility he's placed on 1:1, multiple superficial cuts noted to the right arm, areas cleaned with wound cleanser and triple antibiotic cream applied, no bleeding noted. (R2) sat down and talked with this nurse and voiced that he's just frustrated that he's not able to see his pregnant girlfriend, this nurse asked him if he used any coping skills when he gets upset and emotional like this he voiced no, this nurse gave suggestions on things he can do, he voiced understanding. (R2) voiced that he's still feeling suicidal, and he wants to go to the hospital. (V19, Physician) called gave orders to send to (Regional Hospital) to evaluate and treat. Message left for on call guardian. DON (Director of Nursing) made aware."

R2's Nurse's Note, dated 5/21/22 at 8:00 PM, documents "(Local Ambulance) called, ETA (estimated time of arrival) two to three hours. Facesheet, POLST (Physicians Orders for Life Sustaining Treatment), orders and transfer made for hospital and EMS (Emergency Medical Service)."

R2's Nurse's Note, dated 5/21/22 at 10:00 PM, documents "(Local Ambulance) here. (R2) transported to (Regional Hospital) at this time. (Regional Hospital) called, report given."

R2's Nurse's Note, dated 5/22/22 at 10:04 AM, documents "(R2) returned from (Regional Hospital) at this time. NNO (No New Orders). On call Guardian called and made aware."

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S9999	Continued From page 15 R2's Care Plan, dated 5/6/22, documents "(R2) is at high risk for elopement. He has a history of leaving home when he is upset. 12/5/22 (R2) ran out of the building, Dr. Wonder was announced immediately over the intercom and staff went out and immediately brought him back into the building." The facility did not revise R2's care plan with progressive interventions to address R2's self-injurious behavior of cutting. There was no documentation in R2's medical record that the facility provided R2 with increased supervision after R2 displayed self injurious behavior on 5/21/22. There was no documentation of one-on-one done for R2 during 5/21/22 incident. On 01/12/23 at 2:50 PM, V2, Regional Clinical Operations stated, "I know you have concerns with resident safety, and I have to tell you that not only do we have the 1:1 CNA, but we also have hall monitors that help keep an eye on residents and can help if the person doing 1:1 needs assistance. I can tell you that (R2) will be a 1:1 from now until he is discharged from here. The incident when he pushed another resident in the dining room, the staff member who was doing 1:1 with him was probably walking next to him when he did that. There is not much they could have done." R2's Care Plan, revised on 5/24/22 documents "(R2) got into a verbal and physical altercation with another resident." R2's Care Plan Interventions, revised on 5/24/22 documented "Staff to encourage (R2) when he has problem with peer to notify staff to assist. Resident moved to another hall."	S9999		

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S9999	Continued From page 16 R2's Social Service Note, dated 5/24/22 at 7:04 PM, documents "(R2) was involved in a physical altercation with another resident this evening. His state appointed guardian was contacted." On 1/23/23 at 1:35 PM, V20, Regional Clinical Nurse, stated "If the IDT got together in June 2022, regarding (R2), that was before us. We were not here then so cannot answer for what happened then. I do know that (R2) tends to call 911 and act out more when the Administration is gone and that is typically at night and/or the weekends." The Facility's One-On-One Documentation Sheet, dated 9/5/22 through 9/7/22, documents every ten-minute check were completed on R2, indicating his whereabouts. On 1/24/23 at 9:10 AM, V10, LPN, stated "On 5/24/22, we were passing food trays in the hall when (R2) walked past (R6's) room and exchanged words, which triggered (R2) and then a fist fight began. I believe (R6) was punched in the head and because of his traumatic brain injury, and being hit in the head, he was sent to the hospital to be looked at. (R2) was also sent to the hospital and when he came back, I believe - they put him in another room." On 1/24/23 at 9:15 AM, V10, LPN, stated "(R2) was in the dining room on 5/21/22 and I don't recall him being a one-on-one at that time. (R2) then walked out the dining room door to the outside parking lot. We followed him outside and he had a butter knife that he must have gotten off his table. (R2) actually cut his wrist with the knife and he was sent to the hospital. I do not recall what triggered him that day, but it can be anything. Anytime (R2) does not get what he	S9999		

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wants, it's a trigger. For example, if (R2) wants ice cream and the kitchen is out of ice cream, that triggers him, and he has a behavior and can become verbally and physically violent to himself and others."

R2's Care Plan Intervention, revised on 5/23/22 documents "Dietary to provide resident with metal spoon only with meals."

R2's Nurses Note, dated 5/25/22 at 11:33 AM, documents "Resident guardian notified that resident has to be moved to (a different room). Resident has been moved with no complaint or concerns."

R2's Nurse's Note, dated 5/28/22 at 8:36 PM, documents "Staff reported Resident was asked to put mask on, he became upset verbal aggressive toward staff, broke a plate, pulled hand sanitizer off the wall throwing things, unable to redirect, called (V13, MD) new order to send to (Regional Hospital) ER for evaluation."

There was nothing documented in R2's Care Plan related to his aggressive behavior on 5/28/22 and no additional interventions.

R2's Nurses Note, dated 6/11/22 at 8:11 PM, documents "Resident told this nurse (V22, MDS/Care Plan Coordinator) that he called police because he did not want to be here. At 5:20 PM, Resident was lying on the floor telling other residents he could not breathe. When this nurse went to assess him, he became verbally abusive and started breaking the sanitizer dispensers on the wall on 400-hall. At 5:23 PM, Resident went out of 400-hall exit door and started exiting through the doors in the building. Resident was walking around the parking lot while staff was

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S9999	Continued From page 18 trying to get him back into the building. At 5:25 PM, Director of Nursing was called and informed of resident's behavior and that he was being sent out to another hospital. At 5:30 PM, (V19, Physician) was called and informed of this behavior and order was given to send to (Regional Hospital). At 5:35 PM, (Local Ambulance) was called and report was given. At 5:36 PM, Report was given to (Regional Hospital). At 5:37 PM, (Local Police) arrived and was talking to resident outside. (Local Police) said he was taking resident to (Metropolitan Hospital) because resident requested (Metropolitan Hospital). At 5:38 PM, Guardian was call and no message could be left." R2's Care Plan, dated 11/22/22, documents "6/11/22 Verbal and Physical Aggression." There were no interventions documented after this altercation. R2's Nurses Note, dated 6/20/22 at 11:14 PM, documents "IDT (Interdisciplinary Team) has met and reviewed (R2's) behaviors and need for one on one. Pattern noted that (R2) has more behaviors on the weekend's so he will be provided a one on one for weekends." On 1/23/23 at 1:35 PM, V20, Regional Clinical Nurse, stated "If the IDT got together in June 2022 regarding (R2), that was before us. We were not here then so cannot answer for what happened then. I do know that (R2) tends to call 911 and act out more when the Administration is gone and that is typically at night and/or the weekends." R2's Nurses Note, dated 6/22/22 at 3:08 PM by V23, LPN, documents "Staff report Resident is in the dining room throwing tables around hitting at	S9999		

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S9999	Continued From page 19 the windows, threatening staff members. No easily redirected. Call placed to (Local Ambulance) to transport Resident to (Regional Hospital)." R2's Nurse's Note, dated 7/2/22 at 9:22 PM, documents "Resident yelling loudly cussing at staff, walking up and down the hallway to the dining room, pulling pictures off the wall, slamming tables down in the dining room unable to redirect, 1:1 in place, call placed to (Local Ambulance) and Police." The Facility's "Final IDPH Incident and/or Abuse Notification", dated 7/8/22, documents "On 7/8/22, (R2) a 30-year-old male resident with a diagnosis of Bipolar, Schizophrenia DO (Disorder), was physically aggressive with (R11), a 66-year-old male resident with a diagnosis of Schizoaffective DO. Residents were immediately separated. (R11) was interviewed and stated that (R2) open handed made contact with the side of his face. (R2) was interviewed and stated that (R11) was in his way while he was upset. (R11) was assessed, with no redness or swelling was found. Interviewable residents have been interviewed with no finding. Staff interviews have been completed. Medical records for both residents have been reviewed including medication review." It continues "The Facility has taken the following actions based on the facts and conclusions of the investigation: Psych Dr. was notified. (R2) was sent to (Local Metropolitan Hospital) for Psychiatric evaluation, upon return, 1:1, and skills anger management was provided. (R11) continues his daily activity with no signs of mental anguish, IDT has reviewed and updated care plans on both residents accordingly." It continues "Brief description of Occurrence based on known facts at this time prior to a	S9999		

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S9999	Continued From page 20 comprehensive investigation: Resident to Resident physical altercation. Residents immediately separated. Administrator notified. Final to follow." The Facility's Resident Interview, undated, unsigned, documents "(R11) was asked what occurred between him and (R2) which he replied, "I don't know, he slapped me across my face". When (R11) was asked if he was hurt, he said no. When (R11) was asked if he felt safe or was scared of (R2) or anyone at the facility, he stated "Hell No, they don't bother me." The Facility's Resident Interview, undated, unsigned, documents "When (R2) was asked what occurred between him and (R11), he stated "He was in my way." When (R2) was asked if he slapped (R11), he refused to answer and walked away." R11's Admission Record, dated 1/19/23, documents that R11 was admitted to the facility on 6/21/22 and was discharged from the facility on 7/21/22 and therefore, unable to interview. There is nothing further documented in neither resident's medical record regarding this incident. R2's Care Plan, revised on 7/8/22 documented "(R2) was verbally aggressive towards staff." There were no interventions to address his physical altercation with R11. R2's Care Plan revised on 7/09/22 documented "(R2) punched a staff member in the face." No new interventions were added. There was no documentation in R2's medical record regarding this incident. There was no facility investigation regarding this incident.	S9999		

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S9999	Continued From page 21 On 1/12/23 at 11:20 AM, V2, Regional Clinical Operations, stated "We do not need to do an investigation when a resident hit a staff member as it is not a reportable incident." R2's Nurse's Note, dated 7/25/22 at 2:21 PM, documents "Resident was in the dining room flipping table and chairs and knocking things off the table due to being mad that he overheard a staff member ask if it was okay for resident to be off the hall due to COVID isolation restriction. this nurse and two other staff members were able to redirect residents and calm him down and address his concerns." R2's Nurses Note, dated 7/25/22 at 6:15 PM, documents "Resident in dining room this nurse heard commotion and this nurse immediately went to dining area resident was actively throwing chairs and tables chasing staff being combative this nurse asked resident to calm down and explain what happened to him to make upset," stated staff asked him to return to room and he got upset this nurse redirected resident to calm down and to come to management anytime he has and issues this nurse called (V19) gave orders to send resident to (Regional Hospital) this nurse called (Local EMS) currently waiting for transport to arrive to take resident hospital for psychiatric evaluation." R2's Care Plan, revised on 7/25/22, documented "(R2) was throwing chairs at staff members on evening shift and was chasing staff members. (R2) was sent out to hospital for evaluation." The facility did not implement progressive interventions at that time to address this behavior and to prevent R2 from future aggressive behaviors.	S9999		

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S9999	Continued From page 22 R2's Nurses Note, dated 8/5/22 at 5:26 PM, documents "(V13, Physician) made aware of resident sitting himself on the floor and running out of facility multiple times. Resident observed hitting walls in hallway and threatening to kick residents' teeth out. Orders received to send resident to ER for psychiatric evaluation and treat. (Local Ambulance) made aware of transportation needed. Resident made aware of MD orders and requested to go to (Metropolitan Hospital). Notified guardian via voicemail of resident occurrence and MD orders. Ambulance arrived with two EMTs (Emergency Medical Technicians). Documentation and report given to paramedics. Resident cooperative with transfer to stretcher. Exited facility without incident." R2's Care Plan, dated 11/22/22, does not document the incident on 8/5/22, nor does it document any new interventions to be done. R2's Nurse's Note, dated 9/6/22 at 10:37 PM, documents "Resident sent to (Regional Hospital) per (V19) related to aggressive behavior toward staff and destroying facility property, also trying to cut wrist with glass from broken picture frame which resident broke by throwing pictures onto floor. (Local Ambulance) and (Local PD) responded to facility for transfer, POA and DON notified." There was no documentation in R2's medical record that the facility provided R2 with increased supervision after R2 displayed self-injurious behavior on 9/6/22. There was no documentation if staff were directly supervising him at the time of the 9/6/22 incident. R2's Nurse's Note, dated 9/13/22 at 9:54 PM, documents "Resident returned to facility by two	S9999		

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S9999	Continued From page 23 EMS drivers no complaints at this time resident able to ambulate from the stretcher resident. Resident currently resting in bed with no complaints." There is no documentation in R2's medical record that the facility implemented any new interventions to address R2's self-injurious behavior of increased supervision to prevent R2 from self-injuring. R2's Nurse's Note, dated 9/15/22 at 9:37 PM, documents "Resident in reception area yelling staff, was told that resident called the police. Resident stated he did not call police. This nurse was headed to speak with resident, then resident proceeded to run out of the door. This nurse, along with other staff, went out to stop resident from leaving property. Resident became aggressive punched facility van window, then punched out facility window. This nurse and staff tried to intervene, resident then picked up glass from the ground and attempted to cut himself. This nurse was able to get resident to drop the glass, then he began banging his head against the building. This nurse redirected resident to sit in chair and talk about what happened. Resident stated he wanted to go and not be at facility anymore, and he wanted to harm himself. (Local EMS) and Police were called, and this nurse gave report to EMTs (Emergency Medical Technicians). Resident sent to (Regional Hospital) for evaluation. MD (Medical Doctor) notified guardian was called left voice message." The Facility's One-On-One Documentation Sheet, dated 9/13/22 through 9/15/22, documents every ten-minute check were completed on R2, indicating his whereabouts."	S9999		

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S9999	Continued From page 24 R2's Nurse's Note, dated 9/5/22 at 3:30 PM, documents "Writer (V24, Registered Nurse/ RN) having a conversation with another nurse when resident interrupted wanting to talk to writer in office; explained to him writer was working floor as nurse when resident became loud walked away screaming no one here cared about him, as writer attempted to talk to resident he became loud and verbally aggressive walked over the stairway exit opened door and went downstairs as writer walked around to check on resident he was yelling loudly, cursing and had his fist balled up and pulled back to hit aide in her face. Writer interrupted him and attempted to talk to him when he bolted out the exit door yelling how no one cares about him. Two Staff members with resident. (Local Police) called about resident behavior and walking off. (V19, Physician) notified awaiting return call." R2's Nurses Note, dated 9/5/22 at 5:35 PM, documents "When writer (V24, RN) observed resident with aide also observed him with his chest making contact with aide yelling at her and pushing her backwards with his chest." R2's Nurses Note, dated 9/6/22 at 10:37 PM, documents "Resident sent to (Regional Hospital) per (V19) related to aggressive behavior toward staff and destroying facility property, also trying to cut wrist with glass from broken picture frame which resident broke by throwing pictures onto floor. (Local Ambulance) and (Local PD) responded to facility for transfer, POA and DON (Director of Nursing) notified." R2's Nurses Note, dated 9/13/22 at 9:54 PM, documents "Resident returned to facility by two EMS drivers, no complaints at this time, resident	S9999		

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S9999	Continued From page 25 able to ambulate from the stretcher, resident currently resting in bed with no complaints." R2's Care Plan, dated 9/7/22, documents "(R2) displays behavioral Symptoms, and will call 911. 9/6/22, Verbal and Physical behavior and destruction of property. R2's Care Plan Interventions, were not updated after this incident. There were no new interventions in place. R2's Nurse's Note, dated 9/24/22 at 9:24 AM, documents "Resident sent out to hospital due to behaviors and throwing chairs, threatening to harm self and staff, and notified resident was sent to (Regional Hospital) and admitted." There is no documentation of R2 returning to the Facility and there is no documentation of R2's Care Plan updated with new interventions. R2's Nurse's Note, dated 9/24/22 at 9:24 AM, documents "Resident sent out to hospital due to behaviors and throwing chairs, threatening to harm self and staff, and notified resident was sent to (Regional Hospital) and admitted." There was no documentation the facility implemented progressive interventions to address R2's behaviors or to increase supervision after R2's incidents of attempting to self-harm on 9/15/22 and 9/24/22. R2's Nurse's Note, dated 10/1/22 at 10:28 AM, documents "Resident being sent to (Local Hospital) per (V19) for evaluation and treat related to threatening behavior towards staff and eloping to outside to parking lot. Staff one-on-one with resident awaiting (Local Ambulance) for transfer, POA and DON notified."	S9999		

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S9999	Continued From page 26 R2's Nurses Notes dated 10/14/22 at 6:18 PM documents "This nurse was notified that resident stated he was hearing voices and he wrapped a sheet around his neck. This nurse attempted to contact (V19) with no answer. Report then called to (V26) NP with new order to send for psych eval. Call placed to guardian and message left. DON and Administrator made aware. (Local Ambulance Service) called and awaiting transportation. 1 to 1 continues. Will continue to follow." R2's Nurse's Note, dated 10/24/22 at 1:11 PM, documents "At this time (R2) is yelling through the hallway that he wants to get out of here. This nurse asked (R2) if he wants to talk about what got him so upset, he voiced no, and stormed off into the dining area, he walked up to the dining cabinet and punched the glass out, he then picked up a piece of the glass and proceeded to attempt to cut right arm, staff intervened taking the glass away. Superficial cut noted to arm, (R2) then walks over to dining room exit door and walks out, staff with him. Door alarm didn't sound. (R2) redirected back into the facility by staff. Arm cleaned with wound cleanser and TAO (Triple Antibiotic Ointment) applied and dry dressing, NP (Nurse Practitioner) here and is aware. DON is aware. (R2) placed on 1:1." R2's Nurse's Note, dated 10/24/22 at 1:52 PM, documents "Resident could not be seen by (V27, Physician) due to active behaviors, exiting the building, hitting head on wall, verbal aggression." R2's Nurse's Note, dated 10/25/22 at 6:18 PM, documents "(R2) continues on 1:1 for exit seeking and suicidal. He's been calm and cooperative this shift. He's been using coping	S9999		

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S9999	Continued From page 27 skills to help with increased anxiety and is effective. He took medications without difficulties. No behaviors noted this shift." R2's Nurses Note, dated 10/26/22 at 1:49 PM, documents "(R2) continues on 1:1 related to exit seeking, he's been calm throughout this shift. No behaviors this shift. He's able to make needs known. no distress noted." The Facility's One-On-One Documentation Sheet, dated 10/24/22 through 10/28/22, documents every ten-minute check were completed on R2, indicating his whereabouts." R2's Nurse's Note, dated 11/1/22 at 5:51 PM, documents "(R2) voiced to this nurse that he's feeling suicidal and he's hearing voices. (R2) said the voices are telling him to kill himself, (R2) denies having a plan at this time. 1:1 initiated at this time. (R2) encouraged to use coping skills such as music therapy, walking and a snack. (R2) agreed at this time. Will continue to follow up. " R2's Care Plan was not revised after R2's incidents on 10/24 and 11/1/22 of verbalizing suicidal ideations and self-injurious behaviors. The Facility's One-On-One Documentation Sheet, dated 11/1/22, documents every ten-minute check were completed on R2, indicating his whereabouts for the twenty-four-hour period." R2's "One to One Sheet" date starting at 12/05/22 at 3:00 PM and ending 12/05/22 at 11:10 PM. No Progress Notes noted for any behaviors on 12/05/22. R2's Nurse's Note, dated 12/6/22 at 00:45 AM, documents "At 00:40 AM, Resident came and	S9999		

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S9999	Continued From page 28 asked for his HS (bedtime) medications and this nurse told him she could not give them to him and then he started cursing at this nurse. At 00:42 AM, (Local Police Department) called and informed this nurse that resident had called 911 and was talking about committing suicide. (Local Ambulance) arrived to transport resident." R2's Nurses Note, dated 12/4/22 at 11:30 AM, documents "(R2) voiced that he was using his personal phone on the phone with his Dad, roommate (R3) self-talking and (R2) assumed that roommate (R3) threaten his dad, (R2) became homicidal toward roommate, voicing that he's going to kill him. (R2) called 911 from his personal phone, voicing that he wants to go to (Regional Hospital). (R2) transferred to (Regional Hospital), facesheet and POS (Physician Order Sheet) sent. State guardian on call made aware." The Facility's Incident Report Form - Final Report, dated 12/5/22, documents "Description of Occurrence: Resident told nurse he was having homicidal thoughts against residents and family member. Residents were immediately separated from the room. 1:1 support given. (R2) stated that he became upset with his roommate for talking to himself and threatened to harm (R3) and his father. No physical contact was made. (R2) was sent to ER for evaluation. A nursing assessment shows no injuries. Staff and other residents were interviewed with no negative findings. Occurrence Resolution: Care Plans and medical records were reviewed and updated. Resident carried out normal daily routine without signs of distress." R2's Care Plan, dated 12/5/22, documents "(R2) has a history of self-harming as a form of attention seeking. 12/4/22, (R2) was having	S9999		

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S9999	Continued From page 29 homicidal thoughts against his roommate." There were no new interventions documented in his Care Plan after the 12/5/22 incident. There were was no 1:1 sheet noted for 12/06/22. There was no documentation in R2's medical record that the facility implemented progressive interventions to address R2's suicidal ideations and need for increased supervision. R2's Care Plan was not reviewed after the incident on 12/6/22. R2's had a "One to One Sheet" date starting on 12/20/22 at 6:00 AM and ending 12/24/22 at 12:40 PM. R2's Nurse's Note, dated 12/11/22 at 6:03 PM, documents "Resident was walking through dining room and pushed another resident (R1) onto floor and walked away, stated she yelled at him, this nurse received order to send resident to (Regional Psychiatric Hospital) for evaluation and treat per MD, Guardian notified." R2's Nurse's Note, dated 12/11/22 at 11:00 PM, documents "Resident returned to facility via (Local Ambulance)/stretcher accompanied by two attendants. Resident reintroduced to assigned room." R2's Care Plan, updated on 1/12/23, documents "Aggression Care plan continues: 12/11/22 (R2) noted in altercation with another resident." R2's Care Plan Interventions, updated on 1/12/23, documents "Per (V19, Physician) send resident out to the hospital, See aggression Care Plan Interventions." There are no other interventions put into place for the incident on 12/11/22.	S9999		

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S9999	Continued From page 30 R1's Nurses Note, dated 12/11/22 at 6:16 PM, documents "Resident was in dining room and was pushed onto floor by another resident (R2), upon assessment no injury noted resident got herself up from floor and used her walker to walk back to her room. MD, Administrator and POA notified, will continue to monitor." The Facility's Incident Report Form - Initial Report, dated 12/11/22, documents "Description of Occurrence: (R1) was sitting in the dining room with another resident when (R2) walked through. (R1) was complaining about her salad. (R2) made a comment to her about always complaining. (R1) began to raise her voice and stood up losing her balance and falling backwards. Residents were immediately separated and 1:1 support was given. A nursing assessment reveals no injuries. Other residents and staff were interviewed with no negative findings. Occurrence Resolution: (R2) sent out for evaluation related to behaviors shortly after the incident. Care Plans and medical records were reviewed and updated. (R1) carried out her normal daily routine after the altercation without any signs of distress." On 1/12/23 at 3:20 PM, R1 stated "(R2) pushed me purposely. (R2) was standing in the doorway in the dining room and people were trying to get through so I told him he needed to move. (R2) started to yell at me and when I stood up, he walked over to me and pushed me. I went into a chair and me and the chair fell to the floor with the chair on top of me. My leg was hurting me afterwards and I believe they did do an x-ray. I have seen (R2) hit and push other people too. (R2's) very violent and nobody does anything about it. I don't recall seeing a worker walking around next to him. He was by himself when he	S9999		

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S9999	Continued From page 31	S9999		

pushed me over. (R2's) always yelling and cursing at everyone. I am scared of him, and I think some of the staff are scared of him too."

R2's Care Plan, revised on 12/11/22 documented "(R2) noted in altercation with another resident. Interventions: Per (V19), send resident out to the hospital, See aggression care plan interventions." There were no progressive interventions to address R2's physical aggression after this incident.

R2's Nursing Note, dated 12/12/22 at 12:33 PM, documents "Resident continues on 1:1. No behaviors observed, currently lying down in bed."

R2's Social Service Note, dated 12/15/22 at 11:53 AM, documents "(R2) has successfully completed his 72-hour psychiatric evaluation. No behaviors were previously noted or mentioned. The 1:1 does not need to continue."

R2's Social Service Note, dated 12/23/22 at 10:10 AM, documents "This staff (V28, Social Service Assistant) interviewed (R2) to determine if he was still in need of a 1:1. During the interview, (R2) stated that he was no longer angry. He stated that he understands that whenever he gets angry, he can't bolt out of the facility. He knows what resources are available to him when he gets angry. He stated that when it comes to things he wants or want to do, he has to learn not accept that he can't have them, and not get angry. It is this staff opinion that (R2) no longer needs a 1:1."

The Facility's One-On-One Documentation Sheet, dated 12/20/22 through 12/25/22, documents every ten-minute check were completed on R2, indicating his whereabouts."

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S9999	Continued From page 32 R2's Nurse's Note, dated 1/5/23 at 11:22 PM, documents "Resident frustrated with staff about not getting a second ice cream started punching the walls knocking down hand sanitizer stations an also ripping up facility decor, resident called police from his personal cell phone and stated to them he wanted to leave and not come back here and also that he is homicidal, this nurse gave report to (Local EMS) when they arrived resident requested to go to (Local Hospital)." R2's Care Plan, revised on 1/5/23, documents "(R2) displays behavioral Symptoms, 1/05/23 Punched hole in the wall and ripped hand sanitizer off the wall." No new interventions added. On 1/12/23 at 11:45 AM, R3 stated "(R2) always gets in trouble all by himself. (R2) has not threatened me and if he did, he wouldn't win if he tried anything. The staff have not had to separate us before that I can remember. They moved him out and I am not sure where he went." On 1/12/23 at 2:50 PM, V2, Regional Clinical Operations, stated "I know you have concerns with resident safety, and I have to tell you that not only do we have the 1:1 CNA (Certified Nursing Assistant), but we also have hall monitors that help keep an eye on residents and can help if the person doing 1:1 needs assistance. I can tell you that (R2) will be a 1:1 from now until he is discharged from here. The incident when (R2) pushed another resident in the dining room, the staff member who was doing 1:1 with him, was probably walking next to him when he did that. There is not much they could have done."	S9999		

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S9999	Continued From page 33 R2's Nurse's Note, dated 1/13/23 at 10:28 PM, documents "Late Entry: Note Text: Resident made staff aware that he was having chest pain and stomach was bothering him. staff let resident know that they would notify the nurse. While staff went to go get this resident's nurse resident proceeded to call 911. Resident called stating he was having chest pain and wanted to go to the hospital. This nurse arrived after resident made phone call to PD. Resident stated he called because he needed to go and did not want to be treated at the facility he wanted to go to the hospital for treatment. Two EMS arrived at 9:20 PM, as well as two (Local Police) Officers. Resident became agitated with EMS questions and became homicidal towards staff members and suicidal towards self. Resident walked to stretcher and exited facility with no bruises noted A&Ox3 when resident sat on stretcher resident began hitting self with phone in the head and then proceeded to throw phone to the groundbreaking the front screen to the phone. The nurse made resident aware of screen being broken due to resident throwing it resident examined phone and stated he didn't care. Phone was locked away in med cart on 400-hall. Resident exited facility headed to (regional hospital) for evaluation and treatment. Administrator and NP made aware." R2's "One to One Sheet" date starting on 01/12/23 at 6:00 AM and ending 01/16/22 at 6:15 AM, documents every ten-minute check were completed on R2, indicating his whereabouts. On 1/17/23 at 8:45 AM, V8, Hall Monitor, stated "I don't really have many problems with (R2), probably because of my size. He does have certain triggers that will make him upset, and he acts out."	S9999		

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S9999	Continued From page 34 On 1/27/23 at 10:22 AM, V8, stated that "(R2's) triggers depend on his emotions. If certain things don't go his way, or he can't have things that he wants, or if he gets his feelings hurt.' On 1/24/23 at 9:15 AM, V10, LPN, stated "I do not recall what triggers him on any particular day, but it can be anything. Anytime (R2) does not get what he wants, it's a trigger. For example, if (R2) wants ice cream and the kitchen is out of ice cream, that triggers him, and he has a behavior and can become verbally and physically violent to himself and others. The only thing to do is to provide 1:1 with him." On 1/17/23 at 8:50 AM, V9, LPN, stated "I wouldn't want to be a one-on-one with him. He has hit employees before. He needs a big guy to be one-on-one with him. I was here yesterday when he came back from the hospital via ambulance. I don't see anywhere in his chart or the twenty-four-hour sheet that says why he went to the hospital. There were no records from the hospital or anything." On 1/17/23 at 8:55 AM, V10, LPN, stated "I think he's better now than he used to be. The one-on-ones are helping but since his guardian got him a new cell phone, he seems to be better. Now he just calls 911 when he wants to go out." On 1/12/23 at 11:55 AM, V3, CNA, stated "I am doing 1:1 with (R2). All I basically do is write down his location every 10 minutes. I really don't do anything with his behaviors. I guess if I needed help, I could call for someone." On 01/18/23 at 2:05 PM, V15, CNA stated, "I have been here with (R2) since 6:00 AM this	S9999		

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S9999	Continued From page 35 morning. I document where (R2) is or what he is doing every 15 minutes. If (R2) has any behaviors, I really don't do anything but notify the supervisor." On 01/19/23 at 11:50 AM, V4, State Guardian, stated, "(R2) has never been on one-on-one that I know of. Every time I visit, I don't see him with a one-on-one. The facility does not let me know when (R2) does things. They usually wait until I get here and fill me in." On 1/23/23 at 1:50 PM, V9, LPN, stated "(R2) wanted to get out so he complained of suicidal ideations, and he was just sent out. (R2) doesn't really give specifics as to what he may want to do to himself, but I know he will try something because he has done it before. For now, we are just keeping him on 1:1 observation." On 1/27/23 at 10:50 AM, V19, Psychiatrist, stated "In my professional opinion, (R2) is in best place for him right now. He has no place to go. He is not appropriate for a group home, and he cannot survive on the street. (R2) has spent many many years in the system. We have tried therapy, several different medications, and different outpatient resources. (R2) has a lot of attention seeking behaviors and will act up at the facility, and then when he gets to the Emergency Room, is calm and quiet." On 1/12/23 at 2:23 PM, V6, Social Service Director, stated "(R2) is supposed to be attending groups, such as Life Skills, Anger Management, and Community Living, but (R2) will come into the meeting, become very vocal and disruptive, and leave within a few minutes of being there. Sometimes what we are doing for (R2) just	S9999		

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S9999	Continued From page 36 doesn't work. Right now, the only thing we are doing for him is one-on-one. (R2) knows that if he says something suicidal or homicidal, that we will send him out for an evaluation, so he gets out of the building. When he returns, he is put on a 72-hour one-on-one watch. It seems like as soon as his watch/evaluation period is done, he starts to act up again, especially when he doesn't get his way." On 1/12/23 at 2:50 PM, V2, Director of Nursing stated "I know you have concerns with resident safety, and I have to tell you that not only do we have the 1:1 CNA (Certified Nursing Assistant), but we also have hall monitors that help keep an eye on residents and can help if the person doing 1:1 needs assistance. I can tell you that (R2) will be a 1:1 from now until he is discharged from here. The incident when (R2) pushed another resident in the dining room, the staff member who was doing 1:1 with him, was probably walking next to him when he did that. There is not much they could have done." The Facility's "Residents Rights & Residents Safety", dated 7/8/20, documents "These guidelines emphasize a proactive intervention promoting enhanced physical, psychosocial well-being and person-centered care while promoting resident/resident representative care participation. The facility recognizes that there may be occasions in which standard approaches of Q2 hour rounds may need to be increased to more frequent, enhanced observation. Enhanced supervision should take the form of positive interaction, in line with the patient's therapeutic goals." It continues "Q15-minute, Q30-minute, hourly checks - the staff will check observe the	S9999		

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S9999	Continued From page 37 resident's status/whereabouts every 15 or 30 minutes, or hourly. One to one observation - one staff member will be scheduled to provide one to one observation. The scheduled staff member will not have other resident in his/her care assignment. This is an integral part of a therapeutic plan and ensures the safe and sensitive monitoring of the patients physical and psychological well-being, whilst at the same time developing positive therapeutic interactions. It should consider interactions and engagements with the patient that maintains a balance between intrusion and safety." The Facility's Abuse Policy, undated, documents "This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff, or mistreatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents. In order to do so, the facility has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff and mistreatment of residents." It continues "This facility is committed to protecting our residents from abuse, neglect, exploitation, misappropriation of property and mistreatment by anyone including, but not limited to, facility staff, other residents, consultants, volunteers, staff from other agencies providing services to the individual, family members or legal guardians, friends, or any other individuals." It continues "Any allegation of abuse or any incident that results in serious bodily injury will be reported to the Illinois Department of Public Health	S9999		

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S9999	Continued From page 38	S9999		

Immediately, but not more than two hours after the allegation of abuse. Any incident that does not involve abuse and does not result in serious bodily injury shall be reported within 24 hours." It continues "VI. Protection of Residents: The Facility will take steps to prevent potential abuse while the investigation is underway. Residents who allegedly abuse another resident shall be immediately evaluation to determine the most suitable therapy, care approaches, and placement, considering his or her safety, as well as the safety of other residents and employees of the facility. In addition, the facility shall take all steps necessary to ensure the safety of residents including, but not limited to, the separation of the residents."

The Facility's Resident Census and Conditions of Residents, CMS 672, printed 1/25/23, documents the facility has 142 residents living in the facility.

The Facility's Suicide Policy, undated, documents "It is the policy of this facility to act quickly and appropriately if a resident express thought of suicide." It continues "Policy Explanations and Compliance Guidelines: 1. All staff members will immediately report any suicidal ideation to the resident's charge nurse and facility social worker. 2. Immediately notify the resident's physician if the resident presents with suicidal ideation, even if he or she isn't specific about a plan or intent. 3. If applicable, notify the resident's responsible party of the resident's suicidal ideation and any orders received from the resident's physician. 4. The resident will not be left alone. One-on-one care will be provided until arrangements can be made for the resident to receive emergency psychiatric care, or until the resident's physician determines that the risk of suicide is no longer

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S9999	Continued From page 39 present. 5. Objectively and thoroughly document the resident's mood and behaviors, as well as all actions taken, in the medical record. 6. If the resident requires inpatient psychiatric services, State specific guidelines and requirements will be followed." The Facility's Elopement Policy, dated 9/2022, documents "Elopement occurs when a resident leaves the premises or a safe area without authorization (i.e., an order for discharge or leave of absence) and/or any necessary supervision to do so. This does not include alert and oriented residents who handle themselves outside the facility and choose to leave the facility, even if against medical advice and sometimes, common sense. While presenting different care challenges, these alert residents are not in the same category of potential danger as the residents with impaired cognition trying to leave the facility, and their absences from the facility are not considered to be an elopement." It continues "Residents who are at risk to elope are closely supervised to keep them safe in their environment, while allowing them to move freely about the safe environment." 2. R2's Illinois PASRR (Preadmission Screening and Resident Review) Summary of Findings, dated 4/17/22, documents R2 has been diagnosed with an Intellectual Disability. R2 was approved for short term/120 days at this Nursing Facility Level of Care. The PASRR also documents that R2 will require Rehabilitative Services and/or Supports of Pharmacotherapy, including administration and monitoring of the effectiveness and side effects of medications which have been prescribed to change inappropriate behavior or to alter manifestations	S9999		

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S9999	Continued From page 40 of psychiatric illness. This further explains that Medication Management can help the resident take medication correctly. The provision of a structured environment for those individuals who are determined to need such structure (e.g., structured socialization activities to diminish tendencies toward isolation and withdrawal). It further explains that a resident should take part in social activities to help with depression and anxiety. The development, maintenance, and consistent implementation across settings of those programs designed to teach individuals daily living skills necessary to become more independent and self-determining including, but not limited to, grooming, personal hygiene, mobility, nutrition, vocational skill, health, drug therapy, mental health education, money management, and maintenance of the living environment. It further explains that Psychiatric education on your disorder and medications, Crisis intervention services or plan, a safety and crisis plan will help your nursing home staff if you have thoughts of hurting yourself, Individual, group, and family psychotherapy, Counseling from a therapist or counselor could help you learn coping skills. It further explains that you enjoy sports, such as, football and kickball, you like playing games, a good day is "Good things make my day good. Nice day walking outside stuff like that". R2's "Care Plan/Behavior Tracking Record" dated May 2022 documents "Resident has a history of homicidal ideations. Resident is at risk for harm to others." Resident had issues on 05/17/22 and 05/18/22 during the day shift. "Resident has a history of being verbally aggressive." Resident had issues on 05/02/22, 05/04/22, 05/17/22, 05/20/22, and 05/28/22 during the day shift. Resident had issues on 05/02/22, 05/04/22,	S9999		

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S9999	Continued From page 41 05/09/22, 05/15/22, and 05/23/22 during the evening shift. "Resident is at risk for elopement." Resident had issues on 05/02/22, 05/10/22 during the day shift. Resident had issues on 05/17/22 and 05/24/22 during the evening shift. "Resident has a history of calling 911." Resident had issues on 05/07/22 during the day shift. Resident had issues 05/01/22, 05/21/22, and 05/29/22 during the evening shift. "(R2) has history of suicidal ideations. He is at risk for self-harm." Resident had issues on 05/04/22, 05/11/22, 05/15/22, 05/17/22, and 05/18/22 during the day shift. Resident had issues on 05/24/22 during the evening shift. Resident had issues on 05/01/22 during the midnight shift. "Resident has a history of making untrue accusatory statements towards staff and others." Resident had issues on 05/04/22 and 05/07/22 during the day shift. Resident had issues on 05/04/22 and 05/07/22 during the day shift. Resident had issues on 05/14/22 and 05/20/22 during the evening shift. "Resident has a history of being physically aggressive." Resident had issues on 05/04/22, 05/05/22, 05/24/22, and 05/28/22 during the day shift. Resident had issues on 05/01/22 during the evening shift. "Resident has a history of refusing care." Resident had issues on 05/05/22 during the midnight shift. "Resident has a history of faking seizures." Resident had issues on 05/04/22 during the day shift. R2's "Care Plan/Behavior Tracking Record" dated June 2022 documents "Resident has a history of making untrue accusatory statements towards staff and others." Resident had issues on 06/04/22, 06/08/22, 06/11/22, and 06/21/22 during the days shift. Resident had issues on 06/04/22, 06/12/22, 06/16/22, and 06/19/22 during the evening shift. Resident had issues on 06/13/22 during the midnight shift. "(R2) has	S9999		

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signs and symptoms of depression." Resident had issues on 6/17/22 and 06/22/22 during the day shift. Resident had issues on 05/13/22 and 05/18/22 during the evening shift. "Resident has a history of calling 911." Resident had issues on 06/11/22 during the evening shift. "(R2) has a history of destruction of property." Resident had issues on 06//28/22 during the day shift. "Resident has a history of refusing care/meds." Resident had issues on 06/02/22 and 06/10/22 during the day shift. "(R2) has a history of leaving facility unescorted/Elopement." Resident had issues on 06/07/22 and 06/11/22 during the day shift. Resident had issues on 06/11/22 and 06/23/22 during the evening shift. "(R2) is verbally/physically aggressive relate to dx: Schizophrenia." Resident had issues on 06/11/22, 06/16/22and 06/22/22 during the day shift. Resident had issues on 06/06/22, 06/11/22, 06/18/22, and 06/21/22 during the evening shift. "(R2) has a history of suicidal ideations. He is at risk for self-harm." Resident had issues on 06/08/22 and 06/11/22 during the day shift. Resident had issues on 06/07/22 and 06/14/22 during the evening shift. Resident had issues on 06/12/22 during the midnight shift. "Resident has a history of faking seizures." Resident had issues on 06/23/22 during the evening shift.

R2's "Care Plan/Behavior Tracking Record" dated July 2022 documents "(R2) is verbally/physically aggressive related to dx: Schizophrenia." Resident has issues on 07/21/22 during the day shift. Resident had issues on 07/25/22 and 0730/22 during the evening shift. "Resident has a history of calling 911." Resident had issues on 07/30/22 during the midnight shift. "Resident has a history of homicidal ideations. Resident is at risk for harm to others." Resident had issues on 07/05/22 during the midnight shift. "Resident has

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history of making untrue accusatory statements towards staff and other peers." Resident had issues on 07/14/22 during the day shift. Resident had issues on 07/18/22 during the evening shift. Resident had issues on 07/21/22 during the midnight shift. "Resident has a history of being verbally aggressive." Resident had issues on 07/20/22, 07/25/22, and 07/28/22 during the evening shift. "Resident is at risk for elopement/exit seeking." Resident had issues on 07/20/22 and 07/28/22 during the evening shift. "Resident has a history of suicidal ideations." Resident had issues on 07/11/22 and 07/24/22 during the day shift. Resident had issues on 07/11/22 and 07/24/22 during the evening shift. Resident had issues on 07/11/22 and 07/19/22 during the midnight shift. "(R2) has a history of destruction of property." Resident had issues on 07/20/22, 07/25/22, and 07/28/22 during the evening shift.

R2's "Care Plan/Behavior Tracking Record" dated August 2022 documents "Resident has a history of making accusatory statements about staff and/or peers when she feels stressful." Resident had issues on 08/15/22 during the day shift. "Resident has a history of suicidal ideations." Resident had issues with 08/08/22 during the day shift.

R2's "Care Plan/Behaviors Tracking Record" dated September 2022 documents "(R2) is at risk for elopement." Resident had issues on 09/05/22 during the evening shift. "Resident has a history of being physically aggressive with staff/verbally aggressive." Resident had issues on 09/05/22 and 09/15/22 during the evening shift. "Resident has a tendency to refuse medication and care." Resident had issues on 09/03/22 during the evening shift. "(R2) has a history of displaying

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S9999	Continued From page 44 physical self-harm." Resident had issues on 09/15/22 during the evening shift. R2's "Care Plan/Behavior Tracking Record" dated October 2022 documents "Resident has a history of homicidal ideations. Resident is at risk for harm to others." Resident had issues on 10/12/22 and 10/24/22 during the day shift. Resident had issues on 10/29/22 during the evening shift. "Resident has a history of being physically aggressive with staff." Resident had issues on 10/02/22, 10/06/22, 10/12/22, 10/22/22, 10/23/22, 10/24/22, and 10/26/22 during the day shift. Resident had issues on 10/02/22, 10/03/22, 10/09/22, 10/15/22, and 10/3022 during the evening shift. "(R2) is at risk for elopement/exit seeking." Resident had issues on 10/16/22 and 10/25/22 during the evening shift. Facility was unable to provide Behavior Tracking sheet for the months of November, December, and January. The Facility's Subpart S Services policy dated 12/2017 documents "To provide proper services and programming to individuals with a serious mental illness." (B)	S9999		