STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009237	A. BUILDING: _____ B. WING _____	C 05/02/2023

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EASTVIEW TERRACE	100 EASTVIEW PLACE SULLIVAN, IL 61951

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S 000	Initial Comments Investigation of Facility Reported Incident of 3/9/23 / IL159062 Investigation of Facility Reported Incident of 4/15/23 / IL159057	S 000		
S9999	Final Observations Statement of Licensure Violations: 1/2 300.610a) 300.1210b) 300.1210d)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	S9999		

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S9999	Continued From page 1 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. 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: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.3210 General t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property. These regulations were not met as evidenced by: Based on interview and record review the facility failed to protect residents' rights to be free from physical abuse by another resident and failed to implement interventions to prevent reoccurring physical abuse for four of four residents (R1,R2,R3,R9) reviewed for abuse in the sample list of nine residents. These failures resulted in R1 physically abusing R2, R3 and R9. Findings include:	S9999		

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S9999	Continued From page 2 R1's Physician Order Sheet (POS) dated April 2023 documents R1 is diagnosed with Dementia with other Behavioral Disturbances, Graves Disease, Schizophrenia and Psychotic Disorder. R1's Minimum Data Set (MDS) dated 3/13/23 documents R1 is severely cognitively impaired. The same MDS documents R1 has hallucinations, delusions, and wanders. R1's Minimum Data Set (MDS) dated 12/12/22 documents R1 has hallucinations, physical behavior symptoms directed towards others such as hitting, kicking, pushing, scratching. The same MDS documents R1 wanders daily and significantly intrudes on the privacy of others. R1's Psychosocial Evaluation dated 3/30/23 documents R1 demonstrates poor safety awareness, poor judgment, wanders, enters other's bedrooms uninvited, is socially inappropriate, gets angry and aggressive, anxious, agitated, is physically aggressive and physically abusive. R1's Care Plan dated April 2023 documents R1 wanders aimlessly throughout the facility and significantly intrudes on others privacy. Staff are to monitor R1's location every 15 minutes and provide one-on-one supervision when R1 is out of bed ambulating in facility. The same Care Plan documents R1 uses psychotropic medications related to behaviors such as wandering and violent aggression towards staff and others. R1's behavior management program includes one on one staff supervision due to wandering and aggressive behavior when awake and out of bed. The facility's Final Report dated 2/11/23 documents on 2/11/23 at 10:40 AM R1 entered	S9999		

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the dining room during a group activity and sat down on another resident's walker. V5 Activity Aide asked R1 to move off of the walker and R1 began hitting V5 and also struck R3 who was sitting nearby. R3 stated she was just sitting there and R1 struck her on the arm really hard. In order to keep both R1 and other residents safe, R1 was placed on one-on-one supervision when out of bed.

On 4/27/23 at 10:00 AM R3 stated she remembers R1 hitting her on the arm during an activity in the dining room. R3 stated R1 hit her pretty hard and it hurt.

R3's Minimum Data Set dated 3/8/23 documents R3 is cognitively intact.

The facility's Final Report dated 4/21/23 documents on 4/15/23 R1 entered R2's room unsupervised and when asked to leave, R1 began repeatedly hitting R2 in the neck and hit her with a belt.

The Behavior Note dated 4/15/23 at 12:25 PM documents R1 entered R2's room and repeatedly struck R2 in the throat with his fist and then preceded to hit R2 with a belt in the chest.

On 4/25/23 at 2:40 PM V4 Licensed Practical Nurse (LPN) stated R1 is independently ambulatory, severely cognitively impaired, impulsive, physically aggressive, combative with care, has a history of physical aggression with other residents, is very quick and almost walk/runs down the halls, is strong and could hurt other residents. V4 stated she was the nurse on 4/15/23 when R2 came out of her room and up to the nurses station. V4 stated R2 was very upset and said that R1 had wandered into her room and

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as R2 was telling him to leave, R1 started to repeatedly hit R2 in the upper chest/neck area. R2 also stated R1 had his belt in his hand and swung the belt at R2. V4 LPN stated R2 is cognitively intact and was visibly shaken with the incident. V4 LPN stated staff are supposed to provide one-on-one supervision for R1 when he is out of bed, but there is often not enough staff to do so. V4 LPN stated on 4/15/23 R1 was not being monitored one-on-one but really needed to be so that he wouldn't hurt anyone else.

On 4/26/23 at 1:30 PM R2 stated R1 was in her room, and R2 got out of the chair to tell R1 to get out. That is when R1 began hitting R2 on her neck/chest. R2 stated it hurt very bad and R1 is a very strong man. R2 stated R1 had his belt off and it was in his hand, and he swung it at R2 but it did not make contact. R2 said she screamed out and went down the hallway to get help. Staff then went to get R1 out of R2's room. R2 stated she sat down in a chair by the nurses station and was very shaken by the altercation. R2 stated she is very scared of R1 and does not want him near her. R2 stated she has still seen R1 walking around the facility unsupervised since the incident.

R2's Brief Interview for Mental Status (BIMS) Evaluation dated 4/17/23 documents R2 has a moderate cognitive impairment.

The facility's Incident Report Form dated 4/25/23 documents on the evening of 4/24/23 R1 was in the hallway and grabbed R9 around the neck.

On 4/25/23 at 2:40 PM V4 Licensed Practical Nurse stated she worked the evening of 4/24/23 and was at the nurses station when she heard R9 scream out. R9 was in the hallway coming

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towards the nurses station. V4 approached her to find out why she screamed and R9 repeated over and over that the man (R1) put his hands around her neck and she doesn't know why he did that. V4 stated R9 was visibly upset by what happened and she was very confused as to why R1 would do that. V4 LPN stated R1 was not being supervised one on one during the shift because they did not have enough staff to watch him at all times and get their work done.

On 4/26/23 at 1:20 PM R9 stated she does not remember the man putting his hands around her throat but if he did, she would not like it.

R9's MDS dated 4/11/23 documents R9 is moderately cognitively impaired.

On 4/27/23 at 3:30 PM V1 Administrator confirmed R1 was not being supervised one on one during any of the three abuse incidents involving R1. V1 confirmed R1 should have been being monitored one on one due to his history of physical aggression towards others.

On 5/2/23 at 2:20 PM V23 Medical Director confirmed R1 is a cognitively impaired resident who has a history of physical aggression towards others. R1 is ambulatory on his own, wanders, and should have been monitored closely by staff. R1 should not have been allowed unsupervised access to other residents. The facility should have followed their intervention of one-on-one supervision for R1 to keep him and other resident's safe and free from abuse.

The facility Abuse Prevention Program dated 11/28/16 documents the facility affirms the right of residents to be free from abuse. Residents who allegedly mistreat or abuse another resident will

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S9999	Continued From page 6 be removed from contact with that resident during the investigation and the accused resident's condition will be evaluated to determine the most suitable care approaches to implement considering the safety of everyone involved. (B) 2/2 300.610a) 300.1210b) 300.1210d)6) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. 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 resident to meet the total nursing and personal care needs of the resident.	S9999		

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S9999	Continued From page 7 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: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. These regulations were not met as evidenced by: Based on interview and record review the facility failed to provide proper footwear and adequate assistance for R4, resulting in R4's fall with serious injury. R4 sustained nasal fractures that required emergency medical care at the hospital. R4 is one of three residents reviewed for falls on the sample list of 9. Findings include: R4's current diagnoses sheet documents the following diagnoses: "Vascular Dementia, Unspecified Severity with Agitation, Cognitive Communication Deficit and Unsteadiness on Feet." R4's Minimum data Set (MDS) dated 12/14/22 documents R4 has severe cognitive impairment requires extensive physical staff assistance with dressing. The same MDS documents R4 requires limited physical staff assistance with walking in room and in corridors. R4's Fall Risk Assessment dated 12/14/22 documents R4's score of 12 points. The same fall risk assessment documents 10 or more points indicates resident is at high risk for falls.	S9999		

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S9999	Continued From page 8 R4's Health Status Note dated 3/9/2023 at 7:55 PM documents the following: "Note Text: CNA summoned writer to East hallway. res (resident/R4) noted sitting on floor in front of CNA, blood noted to facial area, res (R4) eased back onto pillow, area cleansed. 0.9 cm (centimeter) vertical laceration noted to medial bridge of nose, area approximated and 1 (one) steri-strip applied; swelling noted to nasal area; 6.5 cm x 4 cm (length by width) hematoma noted mid-forehead. Neuros (neurological assessment) initiated and WNL (within normal limits) for res (R4), EMS (Emergency Medical Service) notified at 20:06 (8:06 PM), responded at 20:10 (8:10 PM) and departed facility with res (R4) at 2015 (8:15 PM) in route to (local hospital) ER (emergency room)." R4's Hospital "ED (emergency department) Course/Medical Decision Making" record dated 3/9/23 documents the following: "Diagnostic Studies/Procedures: Exam (examination), CT (computed tomography) of Head after fall. Impression: Acute Fracture of both nasal bones." R4's " IDPH (Illinois Department of Public Health), Final Report" dated 3/17/23 documents the following: "It was reported that (R4) and independent walker (MDS above documents R4 requires physical staff assistance) had a fall that occurred 03/9/23, in the hallway that resulted in a nasal fracture." The same report documents an investigation was conducted, which resulted in the following determination: "Conclusion: The IDT team (Interdisciplinary Team) performed a root cause analysis and has placed appropriate interventions in place. The resident was noted to (sic) not have been wearing the proper footwear at the time of the incident. Staff educated to	S9999		

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ensure (R4) wears shoes or slipper socks while ambulating. (R4) also continues to work with therapy for muscle strengthening."

On 4/25/23 at 2:40 PM, V4 (Licensed Practical Nurse) LPN confirmed R4 fell forward on 03/9/23 and fractured her nose. V4 stated she asked the (V8), CNA who was there, what happened, and at first (V8) denied knowing what (R4) tripped over but eventually admitted to (V4) that she (V8) was walking behind (R4) and hugging (R4) from behind when she (R4) tripped over V8's foot and they both fell to the ground. (V8) yelled for help. (V4) LPN stated (R4's) face was bloody, her nose and mouth were bleeding, (R4) had a goose egg on her forehead, and a small laceration to her nose.

On 4/26/23 at 1:45 PM, V8, Certified Nursing Assistant (CNA) stated "The evening (R4) fell, I was (assigned to) her (R4's) CNA after 2:00 PM. I (V8, CNA) noticed that she was sleeping when I first came in. She did not have socks or shoes on. I didn't get her up for supper or I would have put shoes or non-skid socks on her (R4). I don't know who got her (R4) up (ready for supper). We (staff unidentified) all know that all residents are supposed to have them (shoes or non-slip socks) on, if they can walk. After supper (R4) was sleeping on the couch, again without socks or shoes. When she (R4) woke up, I (V8, CNA) should have put shoes or socks on her. I don't know why I didn't. She walks on her own all the time. I walked with her, on the side of her (R4), in the hall just before she fell (3/9/23). I was holding her hand, as a gesture of kindness. Our hands were linked together and (R4) still had bare feet. Usually, she (R4) walks by herself. She tripped over something, I think it was her own feet. I tried to stop her fall (R4) but I couldn't. She fell face

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S9999	Continued From page 10 first and broke her nose. I felt so bad." On 4/26/23 at 2:10 PM, V16, Certified Nursing Assistance (CNA) adamantly stated "I (V16, CNA) was charting in the break room. I came out to the nurse station to get a drink. I looked down the hall immediately before (R4's) fall. (V8, CNA) was walking behind (R4). (V8, CNA) had her arms wrapped around (R4), about chest high. Like in a bear hug. I took a drink of water and before I could set the water down, I heard (V8, CNA) scream for me to get a nurse. I didn't see the fall itself. But it happened literally, within seconds after I saw (V8, CNA) walking behind (R4) like that. They were both on the floor kind of behind the linen cart. (R4) usually walks alone. (R4) walks pretty slow. (V8, CNA) is hyper-energetic. (V8, CNA) may have been rushing her (R4) a bit. I don't think (V8, CNA) meant to cause (R4) a problem. She (V8, CNA) felt really bad that (R4) fractured her nose." On 4/27/23 at 9:30 am, V18, Regional Director of Clinical Operations/ Registered Nurse stated "I help with reportables (falls with injury, that must be reported to IDPH) and (I) am part of the IDT team that reviews all falls with injury. (R4's) fall, I know (V8, CNA) was walking with (R4) in the hallway. I understood (R4) tripped over her own feet. She did not have proper footwear." V18 also stated "The cause of R4 nasal fracture was the fall, due to the root cause, (R4) was bare foot. It is the standard for safety that all ambulatory residents have on shoes or non-slip-wear to prevent falls." On 4/27/23 at 10:35 am, V1, Administrator/Licensed Practical Nurse confirmed V1 assist with all fall investigations. V1 reviewed R4's fall investigation witness	S9999		

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S9999	Continued From page 11 statements. V1 confirmed V16, CNA statement that documents V8, CNA was walking behind R4 in the hall immediately before the fall. V1, Administrator, "Ok, I understand there is direct correlation that may have contributed to (R4's) fall, with (V8) walking behind (R4). That coupled with (R4) not wearing shoes or non-slip socks." The facility "Fall Prevention" policy dated revised 11/10/18 documents the following: "Policy: To provide for resident safety and to minimize injuries related to falls; decreases falls and still honor each resident's wishes/desires for maximum independence and mobility. Responsibility: All staff Procedure: 1. Conduct fall assessments on the day of admission, quarterly, and with a change in condition. 2. Identify, on admission, the resident's risk for falls. A visual prompt may be placed on the name plaque by the entrance to the resident's room. If used, any assistive device such as a walker or cane will be identified with the same visual prompt to match the prompt at the entrance to the room. This system provides staff a visual alert to monitor those at risk for falls. (blank documentation space) indicates high risk for falls. (The facility should signify what the visual prompt will be and if none is used signify with N/A) All staff must observe residents for safety. If residents with a high risk code are observed up or getting up, help must be summoned or assistance must be provided to the resident." The same facility "Fall Prevention" policy documents "Fall Prevention Interventions: 18. Non skid footwear 33. Remind staff to allow residents to proceed at their own pace." (B)	S9999		