STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001275	A. BUILDING: _____ B. WING _____	C 08/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHLAND NURSING & REHAB	900 EAST SCOTT STREET OLNEY, IL 62450

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S 000	Initial Comments Complaint Investigation 2456139/IL176329	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210a) 300.1210b) 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 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the	S9999		

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S9999	Continued From page 1	S9999		

resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)

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

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 prevent physical abuse of a resident from another resident with a known history of aggression towards other residents in 1 of 3 residents (R1) reviewed for abuse in the sample of 33. This failure resulted in R1 being slapped, choked, and hit in the stomach by R2. These actions would cause a reasonable person to have feelings of fear and insecurity while living in their home.

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Findings included:

R1's Resident Face Sheet documented R1 was admitted to this facility on 5/1/2023 with diagnoses of Dementia without behaviors, Psychotic Disturbance, Mood Disturbance and Anxiety. R1's MDS (Minimum Data Set), dated 5/13/2024, documented R1 with a BIMS (Brief Interview for Mental Status) score of 8 out of 15 total indicating R1 has severe cognitive impairment.

R2's Resident Face Sheet documented R2 was admitted to this facility on 12/9/2023 with the diagnoses of Moderate Dementia with Agitation Intermittent Explosive Disorder, Delusional disorders and Cognitive Communication Deficit among others. R2's MDS, dated 6/20/2024, documented R2 with a BIMS score of 0 out of 15 total indicating R2 has severe cognitive impairment. R2's Care Plan documented a focus problem of: Exhibiting problems of wandering, physical aggressiveness towards staff and other residents, sexually inappropriate towards other residents with a start date for this focus problem of 12/11/2023.

On 8/3/2024 at 8:55am, V10 (Family of R1) said R2 has been a resident at this facility for about three months. V10 said R2 thinks R1 is his wife. V10 said R2 wants to sit by R1 in the dining room and at times puts his arm around R1. V10 said R2 will follow R1 around the unit and if R1 does not go with R2 then R2 becomes angry and becomes belligerent. V10 said R2 has attacked R1 twice, the first time R2 hit and choked R1 and the second time R2 punched R1 in the stomach. V10 said R1 was not injured, did not need to go to the hospital, quickly forgot what happened and calmed down after 90 minutes. V10 said she has

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told R1 to avoid R2 but R1 can't remember anything.

On 8/5/24 at 9:30am R1 was noted in the dining room. At that time R1 was confused and unable to give any details of any altercations involving R2.

A facility form titled Grievance/Concern/Complaint form completed by V10 (Family) on 8/2/2024 documents the following, On two separate occasions (R2) has hit (R1). Previous interventions have failed. (R2) thinks (R1) is his wife and will not leave (R1) alone.

A form in R2's EHR (electronic health record) titled Event Report and dated 6/9/2024 documented R2 had slapped and pushed (R1) up against a wall and started choking her.

A Progress Note in R2's EHR documented, on 6/9/2024 at 1:47pm, V12 and V13 (both Certified Nursing Assistants/CNAs) witnessed (R2) slap (R1), pushed her against the wall and started choking her, CNAs were able to separate R2 and R1.

A form titled Long Term Care Facility-Serious Injury, Incident and Communicable Disease Report dated 6/9/2024 at 1:00pm, documented a physical altercation between R2 towards R1 in which R2 became upset with R1, slapped R1 on the face, pushed R1 into the wall and placed his hands on her neck. Staff immediately intervened and separated R2 and R1. R1 was assessed and found to have no physical injuries.

On 8/5/2024 at 9:45am, V9 (Licensed Practical Nurse/LPN) said on 7/31/2024 in the afternoon, R2 became confused and thought R1 was his

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wife. V9 said when R1 disagreed with R2 and said she was not his wife, R2 became physically aggressive towards R1. V9 said, "I tried to get to R1 because I could see R2 getting angry with R1, but before I could get to them, R2 slapped R1 on the face, pushed R1 into the wall and put his hands on R1's neck." V9 said she, V12 and V13 immediately separated R1 and R2 and neither were found with any injuries after the event.

A form in R2's EHR titled Event Report and dated 7/31/2024 documented R2 hit R1.

A Progress Noted in R2's EHR documented the following on 7/31/2024 at 3:29pm, (R2) grabbed a hold of (R1's) walker and would not let go. (R1) yelled out and when staff came to help, R2 punched R1 in the stomach.

A form titled Long Term Care Facility-Serious Injury, Incident and Communicable Disease Report dated 7/31/2024 at 3:30pm, documented a resident to resident altercation in which (R2) grabbed a hold of R1's walker and would not let go. (R1) yelled out for help and as staff approached , (R2) hit (R1) in the stomach. Staff separated R2 from R1. R1 was assessed and found to have no physical injuries.

On 8/5/2024 at 10:00am, V11 (Housekeeper) said on 7/31/2024, she witnessed R2 become angry with R1 for not believing she was his wife and when R1 refused R2, R2 hit R1 in the stomach. V11 said she and V5 (CNA) immediately separated R1 and R2. V11 said neither R1 nor R2 had any injuries from the event.

On 8/5/2024 at 10:45am, V1 (Administrator) said she investigated two allegations of abuse for R2 towards R1 for dates of 6/9/2024 and 7/31/2024

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S9999	Continued From page 5 in which R2 was physically abusive to R1 and both events are substantiated as abuse. V1 said R2 did physically abuse R1 on both of those dates and new interventions have been put into place for both events. V1 said on 7/31/2024, R2 was placed on 15 minute checks and will remain on 15 minute checks indefinitely due to R2's cognitive level and repeated events with R1. A facility policy titled Abuse Prevention Program (revision date 9/29/2022) documents the following: Definition of abuse in part as, The willful infliction of injury, intimidation or punishment with resulting physical harm, pain or mental anguish and This facility desires to prevent abuse, neglect, or misappropriation of property by establishing a resident sensitive and resident secure environment. (A)	S9999		