STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001531	A. BUILDING: _____ B. WING _____	C 10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNT VERNON HEALTH CARE CENTER	#5 DOCTORS PARK MOUNT VERNON, IL 62864

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S 000	Initial Comments Complaint Investigation 2457687/IL178400	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1810b) 300.1810c)1)3) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually 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	S9999		

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care needs of the resident.

Section 300.1810 Resident Record Requirements

b) The facility shall keep an active medical record for each resident. This resident record shall be kept current, complete, legible and available at all times to those personnel authorized by the facility's policies, and to the Department's representatives.

c) Record entries shall meet the following requirements:

1) Record entries shall be made by the person providing or supervising the service or observing the occurrence that is being recorded.

3) Medical record entries shall include all notes, orders or observations made by direct resident care providers and any other individuals authorized to make such entries in the medical record, and written interpretive reports of diagnostic tests or specific treatments including, but not limited to, radiological or laboratory reports and other similar reports.

This requirement was not met as evidence by:

Based on interview and record review the facility failed to prevent resident to resident abuse for 1 (R2) of 3 residents reviewed for abuse in a sample of 26. This failure resulted in R2 being pushed down and verbally threatened by R1 and R2 being fearful of R1.

Findings include:

R1's Admission Record documents and

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admission date of 4/21/23 with diagnoses including: dementia with unspecified severity with agitation. R1's New Admission Information Sheet documents a diagnosis of Dementia with Behavior. R1's Diagnosis Sheet (undated) documents a diagnosis of: dementia with aggressive behavior.

R1's care plan documents a focus area of: the resident (R1) has potential to be physically aggressive to staff and other residents r/t (related to) dementia with a revision date of 07/18/24. The interventions listed include: administer medications as ordered; monitor/document for side effects and effectiveness; analyze times of day, places, circumstances, triggers, and what de-escalate behavior and document; assess and address for contributing sensory deficits; assess and anticipate resident's needs: food, thirst, toileting needs, comfort level, body positioning, pain and etc. (et cetera); communication: provide physical and verbal cues to alleviate anxiety, give positive feedback, assist verbalization of source of agitation; assist to set goals for more pleasant behavior; encourage seeking out of staff member when agitated; give the resident as many choices as possible about care and activities; monitor/document/report PRN (as needed) any s/sx (signs or symptoms) of resident posing danger to self and others; psychiatric/psychogeriatric consult as indicated; and when the resident becomes agitated: intervene before agitation escalates, guide away from source of distress, engage calmly in conversation, if response is aggressive, staff to walk calmly away and approach later. All interventions are dated 06/27/2024.

R1's Minimum Data Set (MDS) dated 07/29/24 documents a Brief Interview for Mental Status

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(BIMS) score of 02, indicating R1 has severe cognitive impairment. Section E, Behaviors, under Behavioral Symptoms documents that physical behavior symptoms directed towards others occurred 1 to 3 days during the assessment period.

R1's Behavior Tracking Record dated September 2024 documents target behaviors of agitation and aggression. A "0" is documented on all days through 9/26/24, including 9/24/24, indicating R1 had no behaviors.

R1's Nurse's Notes dated 09/24/24 at 6:45 AM documents: resident was involved with peer on peer with other resident. This resident was the aggressor. (R1) pushed other resident, hit her and knocked her down to the floor and stated, "I'm going to kill you."

R1's Nurse's Notes dated 09/24/24 at 6:55 AM documents: spoke with (psychiatric office) new order to send resident to ER (Emergency Room) for psychiatric evaluation.

R1's Emergency Department Notes from the local hospital dated 09/24/24 documents a Chief Complaint of "Aggressive Behavior." A provider notes dated 9/24/24 at 7:50 AM documents "presents to ED (Emergency Department) from (name of facility) for aggressive behaviors. Calm and docile for EMS (Emergency Medical Services). NH (Nursing Home) reports he had an altercation with a female resident in the facility."

R2's Physician Order Sheet dated 09/01/24 to 09/30/24 documents a diagnosis of dementia dated 12/09/23. R2's MDS dated 09/18/24 documents a BIMS score of 03, indicating R2 has severe cognitive impairment.

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R2's Nurse's Notes dated 09/24/24 at 6:45 AM document: CNA (Certified Nurse Aide) yelling from dining room, this writer (V4-Registered Nurse) ran to the dining room to find resident on the floor with another resident standing up. CNA stated "he hit her and pushed her over." Housekeeping saw resident go down and wrote a statement. Resident peer stated " I'm going to kill you" when resident went down she fell on her right side - arm, elbow, hip and face.

R2's ED (Emergency Department) nurse timeline notes from the local hospital dated 09/24/24 at 8:20 AM documents: patient presents with right arm/leg pain after another resident pushed her down. At 8:50 AM the notes document: slight grimace with movement of right knee and right elbow. R2's Hospital notes dated 09/24/24 documents: final diagnoses: contusion of right elbow; unspecified dementia, unspecified severity without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety; pain in right knee; headache; and cervicalgia.

On 09/27/24 at 8:40 AM, R2 stated she was scared. When asked why, R2 stated because of the fight. R2 then stated, that man, he's mean.

On 09/27/24 at 10:12 AM, V4 (Registered Nurse) stated that R1 can be nice and then all of the sudden something can agitate him and he can become aggressive. She was working when the peer to peer incident happened between R1 and R2. V23 (Housekeeping) witnessed the event and yelled for assistance. She made the report, assessed the residents and sent them out for evaluation.

On 10/01/24 at 2:10 PM, V18 (Certified Nurse

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Aide) stated she saw R2 later in the day on 09/24/24 after she returned from the hospital. V18 stated that R2 could not specify where she was hurting but she was trying to tell her about the incident.

On 10/01/24 at 1:45 PM, V23 (Housekeeping) stated that she was in the hall cleaning looking in the dining room when the incident between R1 and R2 happened. R1 and R2 were sitting at the same table when R1 got up abruptly and went over to R2. R2 stood up from her chair and R1 started yelling at R2. R1 then hit R2 and pushed R2 down. She ran over to them to try to keep R2 from hitting her head and yelled for help at the same time. There was no other staff in the dining room, the nurse on duty was at the nurse's station and the CNA's were assisting other residents. V23 stated, R2 was scared and complained her arm and leg were hurting.

A final investigation report received by the Illinois Department of Public Health from the facility from V1 (Administrator) on 9/27/24 documents "On 9/24/24 at approximately 6:50 AM, it was reported to this administration by (V3-Assistant Director of Nursing) that an alleged peer to peer incident happened between (R2) and (R1)." The report further documents that "(V23-Housekeeper) stated that she was in the dining room and looked up to see (R1) standing from his seat and he began to yell towards (R2). (R2) then stood from her chair and (R1) moved towards her and pushed her to the floor while telling (R2) that he wanted to kill her. (R2) then said that she was scared." The report concludes "the facility can substantiate that no injuries occurred following the interaction between (R2) and (R1)."

The facility policy, dated 11/28/16, titled "Abuse

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S9999	Continued From page 6 Policy and Procedures" documents in part: this facility affirms the right of our residents to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined below. This includes, but is not limited to, freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident ' s medical symptoms. This facility therefore prohibits mistreatment, exploitation, neglect or abuse of its residents, and 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 mistreatment, exploitation, neglect or abuse of our residents. This will be done by: dementia management and resident abuse prevention. (B)	S9999		