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	IL6008155	A. BUILDING: _____ B. WING _____	C 09/06/2024

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S 000	Initial Comments Facility Reported Incidents of 8/18/24/IL177472 8/29/24/IL177475	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.3240a) 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 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These regulations were not met as evidenced by: Based on observation, interview, and record review the facility failed to protect the residents' right to be free from physical abuse for 3 (R5, R2,	S9999		

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and R3) of 4 residents reviewed for abuse. These failures resulted in R5, getting hit on the top of the head by V9 (Certified Nurse Assistant/CNA), as well as R2 and R3 engaging in a verbal and physical altercation while unsupervised that resulted in injuries (scratch wounds). This failure resulted in R5, who is cognitively impaired, as a reasonable person that would not expect to be harmed in their own home or health care facility, causing them to feel fear, anxiety, and anger.

Findings include:

1. R5 is 58 years old, initially admitted in the facility on 5/1/2018. R5's medical diagnosis includes hemiplegia and hemiparesis following cerebrovascular disease affecting left dominant side, convulsion, schizophrenia, dementia, mood disturbance, and anxiety. R5 has a BIMS (Brief Interview of Mental Status) of 0 dated 6/3/2024 that means R5 rarely or never understood.

Per facility incident report involving R5 and V9 (former Certified Nursing Assistant), it documents as follows:
On 8/29/2024, approximately 11:30 AM, another resident (R6) reported that she witnessed V9 "smack" R5 in his head. V9 denies the allegation. R5 was not able to provide statement due to impaired cognition. R7 who is R6's roommate reported that she did not directly observe the incident, but she heard R6 yell, "she just hit him on the head."

Per R6's written statement dated 8/29/2024, R5 entered my room and started to go towards the bathroom. I (R6) pulled the call light for CNA (certified nursing assistant) assistance. V9 entered the room and got behind the wheelchair and smacked R5 on the head.

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After final investigation by the facility, the incident that happened on 8/29/2024 between V9 hitting R5 on the head was substantiated.

On 9/3/2024 at 1:10 PM, R5 was seen sitting in his wheelchair with his family that introduced to be his mother and his niece. R5 was not able to make conversation when asked, does not elaborate, or make complete statement within topic. On R5's right side of his head, a dent can be seen 3 to 4 inches in size. R5 was able to move around by wheeling his wheelchair.

On 9/3/2024 at 1:19 PM, R6 stated that she remembers V9 came in her (R6) room, got behind the wheelchair of R5, and smacked R5 on the head. Per R6 it happened after R5 came inside the room heading to the bathroom. R6 pointed to the bathroom door about 4 to 5 feet away on the right side of R6's bed. When she (R6) pulled the call light, V9 went in and without saying a word hit R5 on the side of his head where there is a "caved in" area on R5's head. R6 said, "Did you see R5? One side of his head has a caved in." R6 stated, "Oh my! What had just happened she just smack him on the head." R7 who was R6's roommate was laying on her bed which was located on the right side of R6. R7 stated that she heard R6 saying, "Oh my XXXX what had just happened she just smack him on the face." R7 stated that she was laying on the bed and heard R6 stated those words, that V9 hit R5 on the face.

Per MDS (Minimum Data Set) assessment:
R6 has a BIMS (Brief Interview of Mental Status) dated 6/2/2024 of 15. R7 has a BIMS (Brief Interview of Mental Status) dated 7/3/2024 of 14. Both R6 and R7 cognitions were intact.

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On 9/4/2024 at 9:44 AM, V9 (former Certified Nursing Assistant) stated that R5 was confused when he went inside the room of R6 and R7. V9 stated, "When I get there, I said let's go. It's not like I hit him. If you see his head, do you think I will hit his head." V9 stated that she had a good relationship with R6 and R7. She (V9) does not know why they (R6 and R7) say that I hit R5. V9 was asked if there were other staff or residents that can verify that she did not hit R5. V9 stated that no one can verify her statement because it was only her (V9), R5, R6 and R7. V9 stated that she understands that she is in a bad position because R6's statement is backed up by R7.

On 9/5/2024 at 9:34 AM, V2 stated that she was in the dining room feeding a resident when R6 told her that V9 hit R5. R6 told her that R5 went inside R6's room, so R6 pulled the call light. V9 went inside the room and hit R5. V9 was brought downstairs to V1 (Administrator) and was informed about the allegation of abuse and was told that V9 will be suspended pending investigation. V9 did not report to anyone about the incident and it was the same day the incident was reported to her by R6 before lunch.

On 9/5/2024 at 10:03 AM, V10 (Licensed Practical Nurse) stated that she was in-charge of R5 when the incident happened. R6 reported to V2, then V2 reported to her (V10) that was when she knew about the incident. V9 did not report to her (V10) about anything related to the incident. V10 said that R5 was assessed and V1 (Administrator) was notified.

Due to the result of the final investigation conducted by the facility, V9 was terminated. Facility submitted employee report documents

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that read, V9 was suspended on 8/29/2024 and terminated on 8/30/2024. Per facility employee report, V9 was on 90-day (PIP) performance improvement plan on 7/9/2024 due to discourteous behavior. On 9/4/2024 at 1:34 PM, V11 (Business Manager) verified employee report dated 8/29/2024 and 8/30/2024. V11 stated that it was V2 (Director of Nursing) who did the write up of V9 for discourteous behavior on 7/9/2024.

On 9/4/2024 at 1:44 PM V2 (Director of Nursing) stated that on 7/9/2024 V9 was tasked to escort a resident to an appointment. That resident was in a wheelchair with shortness of breath (SOB) and has an order for oxygen as needed. V9 was informed the resident needed a wheelchair, despite being informed that the resident needed a wheelchair, V9 brought the resident to an appointment ambulating without using a wheelchair and the resident has shortness of breath.

2. R2 is 54 years old, initially admitted on 10/2/2023, with medical diagnosis of Chronic Obstructive Pulmonary Disease (COPD), Schizoaffective Disorder, Bipolar Type. R2's Brief Interview for Mental Status (BIMS) dated 7/17/2024 scored 15 that means R2 is cognitively intact.

R3 is 64 years old, initially admitted on 8/6/2016, with medical diagnosis of Major Depressive Behavior, Restlessness and Agitation, Drug Induced Movement Disorder, Schizoaffective disorder, Bipolar, Schizophrenia, Anxiety Disorder. R3's Brief Interview for Mental Status (BIMS) dated 7/4/2024 scored 13 that means R3 is cognitively intact.

Final Incident Investigation Report documents

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that on 8/18/2024 R3 and R2 allegedly engaged in both a verbal and physical altercation while on the patio/smoking area. R3 sustained a superficial scratch to his nose which was treated immediately. R3 asked R2 for cigarette. R2 declined to provide R3 cigarette. R3 struck R2 in the face. R2 scratched R3 on the nose. This incident was substantiated that it did occur.

Immediate Incident Investigation Report by V5 (Licensed Practical Nurse) documents:
8/18/2024, 1:30 PM at the facility patio. R3 sustained superficial injury to his nose.
Residents written statements attach in facility's investigation are the following:
R2's statement: R3 asked me for cigarettes. I (R2) told R3 she does not have cigarettes. R3 yelled at me (R2), I (R2) told R3 to stop, and chairs got tangled. R3 hit me (R2) to my head. I (R2) scratched him (R3) to his face.
R3's statement: I (R3) and R2 on the 1st floor got into a verbal argument over cigarette at the patio. I (R3) accidentally got scratched on the face.
R8's statement: R3 hit R2 in the head and R2 scratched R3.
R9's statement: R2 was leaving the patio, R3 came out and sat by the end. R2 was trying to get by R3 to get inside the building. R2 told R3 to move and R3 would not move. Then R2 and R3 had some words. R3 hit R2 on the back of her head and smushed her face. R2 then hit R3 in the face and scratched R3's face. R2 and R3 were arguing prior to the fight.

Written statements attached in facility's investigation by facility staff:
V6 (Registered Nurse) documented R4 called his (V6) attention that there was an altercation outside between 2 residents. They (R2 and R3) got into verbal arguments and later led to physical

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aggression over cigarette.
V7 (Certified Nursing Assistant) documented that R4 called his attention outside that there is altercation between R3 and R2. I (V7) and the nurse (V6) went outside immediately and asked what happened. R2 said that R3 hit her first because she refused to give R3 cigarette. All of this transpired around 1:40 PM.
V5 (Licensed Practical Nurse) documents that V6 brought R3 to her. I (V5) saw him (R3) with superficial scratch to his nose. At this point R3 was bleeding. I (V5) immediately stopped the bleeding and asked R3 what happened? R3 said, himself (R3) and R2 got into a verbal argument that later led to physical aggression over a cigarette.

V12 (Assistant Director of Nursing/Quality Assurance/Infection Prevention) documents R4 is not writing a statement. He does not want to get involved.

On 9/3/2024 at 1:03 PM, R2 stated it happened in the patio smoking area that R3 asked for a cigarette. When I (R2) said no, R3 tried to take the cigarette in my mouth. Then R3 started swinging hitting me (R2) on the face and head. I went under R3 and scratched R3. There were no staff present during that time. R2 stated that during scheduled cigarette break it is often that no staff is around. R2 stated that both (R2 and R3) was sent out to the hospital.

On 9/3/2024 at 2:01 PM, R3 when asked if he knew R2. R3 stated, "I got in a fight, we had an argument and I don't want to talk about it anymore." R3 was asked if he can elaborate what happened. R3 replied, "I don't want to talk about it anymore!" R3 seems agitated, being asked about the incident. No more question about the incident

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was asked to avoid R3 becoming upset.

On 9/3/2024 at 2:07 PM, R4 was asked about the incident between R2 and R3. R4 stated, "I was told even if I see something, I saw nothing." R4 then stated, "R3 know what he did, he knows he was wrong. What am I supposed to do seeing him keep on hitting her (R2). She (R2) did the right thing fighting him (R3) back." R4 further stated that it was not right to send R2 out to the hospital, but the rule was if one goes the other also needs to go. R4 said, "I don't put up for a man beating up a woman."

On 9/3/2024 at 2:15 PM, V13 (Security Staff) stated that she was not working when the incident between R2 and R3 happened because it happened on a weekend.

On 9/4/2024 at 10:52 AM, V6 (Registered Nurse) stated that during the incident both her (V6) and V7 (Certified Nursing Assistant/Security) were in the building while R2 and R3 were out at the patio which is the smoking area. Then R4 called their attention that there was fighting outside. V6 stated that she went outside and saw R3 had blood on his nose. Then she (V6) went to take care of R3's bleeding nose. V6 said that she then took R3 to the 3rd Floor because R3 is a resident of that floor. She (V6) delivered R3 to V5 (Licensed Practical Nurse) to be taken care. R2 told her (V6) that R3 asked for cigarettes and R2 told R3 that she does not have any cigarettes. R2 and R3's wheelchair tangled and R3 started hitting R2, so R2 scratched R3. V6 said, "She (R2) has nails, so it starts bleeding." Both R2 and R3 were sent to the hospital. V6 stated that when the incident happened there was no staff present.

On 9/4/2024 at 11:10 AM, V5 (Licensed Practical

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Nurse/Restorative Nurse) stated that he was the nurse on the 3rd Floor taking care of R3. On the day of the incident between R2 and R3, R6 brought R3 to him on the 3rd Floor. R3 was covering his nose, it was bleeding. V5 asked R3 what happened and R3 stated that he had physical aggression with R2. V6 said, "R3 has anger issue he gets upset quick."

On 9/5/2024 at 10:14 AM, V8 (Social Service Director) stated that R3 had an incident in the past. R3 called her (V8) attention that in the elevator he (R3) bumped another resident. R3 told her (V8) "I did not hit him." V8 stated that R3 said that after he (R3) bumped another resident that resident told R3 that he (R3) hit him. V8 stated that the problem was due to maneuvering of R3's wheelchair. V8 stated that R3 has aggressive behavior often and that is his usual mood and behavior. V8 stated that per assessment of V14, R1 needs supervised smoking. V8 said that supervised smoking means, R3 needs security to stay outside while R3 smokes. Progress notes of V8 dated 8/16/2024, document that R3 approached V8 stating, "I didn't hit him!" R3 was redirected not to yell and to talk to V8.
V8 then reviewed R3's care plan. Per R3's care plan it documents as follows: R3 is non-compliant with safe smoking that includes begging, borrowing, stealing, selling and/or trading for smoking materials. Under behavior symptoms, R3 exhibits verbally abusive behavior towards staff as evidenced by yelling at peers and staff when he is not getting his way or the answer he wants. Intervention includes, to provide assistance when smoking in the designated area.

On 9/5/2024 at 11:01 AM, V2 stated that during that time when R3 and R2 had verbal and

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physical aggression it was not the usual smoking time. R3 has an order to be independent out on pass. V2 was asked if staff are monitoring residents in the patio or smoking area when they are out smoking, and it is not smoking time. V2 said, "Yes, but at that time no staff was present. V2 was asked would it help to prevent the incident if staff was present prior to or during R2 and R3's incident. V2 did not answer.

On 9/5/2024 at 1:12 PM, V1 (Administrator) was made aware of the two (2) incidents that are abuse concerns.

Abuse Prevention Program dated 10/2022, reads: Per policy, the facility affirms the right of residents to be free from abuse. The facility therefore prohibits abuse. 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. This facility is committed to protecting our residents from abuse by anyone including, but not limited to, facility staff, other residents, or any other individuals. Abuse means any physical or mental injury upon a resident other than accidental means.
Abuse is the willful infliction of injury resulting to physical harm, pain to a resident. Physical abuse includes hitting, slapping, pinching, kicking, and controlling behavior through corporal punishment.
Under Establishing a Resident Sensitive Environment - This facility desires to prevent abuse by establishing a resident sensitive and resident secure environment. This will be accomplished by a comprehensive qualify management involving the following: Resident assessment: Staff will identify residents with increased vulnerability for abuse, who have

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S9999	Continued From page 10 needs, triggers and behaviors that may lead to conflict. Through the care planning process, staff will identify any problems, goals, and approaches, which may reduce the chances of abuse. Staff will continue to monitor the goals and approaches on a regular basis and update as necessary. Staff Supervision: Supervisors will monitor the ability of staff to meet the needs of residents, including that assigned staff have knowledge of individual resident care needs. Situation such as insensitive handling, or impersonal care will be corrected as they occur. (B)	S9999		