STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003792	A. BUILDING: _____ B. WING _____	C 10/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIPER CITY REHAB & LIVING CTR	600 MAPLE STREET PIPER CITY, IL 60959

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S 000	Initial Comments Investigation of Facility Reported Incident of 10/10/24/IL179534	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 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 300.3210 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 a residents (R2) right to be free from physical abuse by another resident (R1).	S9999		

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This failure affects two (R1, R2) out of three residents reviewed for abuse in the sample list of five residents. This failure resulted in R2 being punched in the face by R1 and sustaining a cut above R2's eye.

Findings include:

R1's Facility Census documents R1 was admitted to the facility on 10/2/24 and has the following medical diagnoses; Dementia, Pain, Chronic Fatigue, Diarrhea, Type 2 Diabetes Mellitus, Hyperlipidemia, Long Term Use of Anticoagulants, Benign Prostatic Hyperplasia with Lower Urinary Tract Symptoms, Vitamin D Deficiency, Myalgia, Persistent Atrial Fibrillation, Nausea with Vomiting, Presence of Cardiac Pacemaker, Stenosis of Coronary Artery Stent, Hypomagnesemia, Cervicalgia, Chronic Kidney Disease Stage 3, Diastolic (Congestive) Heart Failure, Dementia, HTN and constipation.

R1's Minimum Data Set (MDS) dated 10/15/24 documents R1's Brief Interview for Mental Status (BIMS) score 5, severe cognitive impairment.

R2's Facility Census documents R2 was admitted to the facility on 10/7/24 and has the following medical diagnoses; Hypertensive Heart Disease, Retention of Urine, Gastritis with Bleeding, Anemia, Atrial Fibrillation, Hemiplegia and Hemiparesis following Cerebral Infarction Affecting Left Non-Dominant Side, Long Term (Current) Use of Insulin, Cervicalgia, Dysarthria and Anarthria, Flaccid Neuropathic Bladder, Low Back Pain, Type 2 Diabetes Mellitus with Foot Ulcer, Protein-Calorie Malnutrition, Atherosclerotic Heart Disease, Hyperlipidemia, Pain in Right Knee and GERD.

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R2's Minimum Data Set (MDS) dated 10/18/24 documents R2's Brief Interview for Mental Status (BIMS) score 15, cognitively intact.

R2's Physician's Order Sheet dated 10/8/24 documents Plavix (Blood thinner) Oral Tablet 75 milligrams, give 1 tablet by mouth one time a day related to Atrial Fibrillation.

Local Sheriff's Department Police Report#20243569 dated 10/10/24 at 5:14am documents, At approximately 5:20am V9 Sheriff's Deputy and Sergeant were dispatched to respond to (facility address) regarding an Aggravated Battery that occurred at the nursing home between R1 and R2. At Approximately 5:45am V9 and V9's Sergeant arrived at the nursing home. V9 was met by V7 Agency Licensed Practical Nurse. V7 advised that on V7's checks R2 informed V7 that R1 had hit R2 in the left eyebrow area. It should be noted that R2 is blind in both eyes, V7 advised that R2 had a cut from the incident and had bled. V7 also advised that R1 suffers from Dementia. V7 escorted V9 to R1 and R2's room. R2 was the only one in the room at this point. R2 advised to V9 that R1 had hit R2 in the eye because R2 was getting extra help from the nurses and R1 did not like this. R2 advised to V9 that R2 did not need any immediate medical attention and the bandage R2 was given by staff fixed the issue. R2 was not in any pain from this incident. V7 then escorted me to where R1 was. R1 was sitting in a wheelchair in the common area. V9 spoke with R1 and R1 advised to V9 that he hit R2 because R1 needed to. It became apparent that R1 was suffering from Dementia. V9 spoke with V3 Assistant Director of Nursing and V3 advised that V3 wanted an information report of the incident.

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On 10/24/24 at 11:05am R2 said, a couple of weeks ago on the night shift, R2 was lying in bed and R1 got up and used the restroom. R2 said, R1 came out of the bathroom and began to yell at R2 stating "R1 is sick of people coming into the room to change your brief". R2 said, R1 then came over to R2's bed and punched R2 above the left eye, causing a cut and blood on R2's face. R2 said, R2 didn't see R1 coming because R2 can't see. R2 said, R2 didn't say anything to provoke R1 in hitting R2. R2 said, V5 (Agency Licensed Practical Nurse/LPN) and V6 (Certified Nursing Assistant/CNA) came in and removed R1. R2 said, V3 (Assistant Director of Nursing/ADON) and other facility staff have spoken to R2 and R2 has told them that R1 just hit R2 in the face for no reason. R2 said, the police came and spoke to R2 and R2 told them that R1 punched him in the eye for no reason.

On 10/24/24 at 12:15pm V7 (CNA) said, at 4:00am while conducting rounds V6 (CNA) came to V7 and told V7 that R2 was bleeding and covered in blood. V7 said, V7 went to R2's room and V5 (Agency LPN) was in them room and told V6 to get R1 out of the room. V7 said, R1 was removed from the room, and V7 administered first aid to the cut above R2's left eye.

On 10/24/24 at 1:54pm V5 (Agency LPN) said, on 10/10/24 at 4:00am while doing rounds with V6 (CNA), V5 and V6 entered R2's room and observed blood all over R2's pillow. V5 said, V5 asked R2 what happened and R2 stated "R1 just punched R2 upside the head". V5 said, V5 asked R1 if R1 hit R2 and R1 stated "[R1] socked the hell out of R2". V5 said, R2 is on a blood thinner so that's probably why there was so much blood.

On 10/25/24 at 11:05am V3 (ADON) said, on

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S9999	Continued From page 4 10/10/24 V3 was notified of an incident between R1 and R2. V3 said, V3 responded to the facility and interviewed V5, V6 and V7. V3 said, V3 interviewed V5 who informed V3 that at 4:00am V5 was assisting V6 (CNA) with rounds, and they entered R2's room and observed blood all over R2's pillow. V3 said, V5 asked R2 what happened and R2 told V5 that R1 just punched R2 upside the head for no reason. V3 said, V5 asked R2 if R1 hit R2 with an object, and R2 told V7 "no" only R1's fist. V3 said, V5 then asked R1 if R1 hit R2 and R1 acknowledged that R1 punched R2 in the head. V3 said, V3 interviewed R1 and R1 told V3 that R1 hit R2 in the head. V3 said, R1 was not able to elaborate to why R1 hit R2. V3 said, V3 interviewed R2 and R2 told V3 that R1 got mad because R2 was getting all the help and attention from staff, and that R1 just got mad and punched R2 in the head. The facility policy titled 'Abuse Prevention and Reporting', revised 11/28/16, documents this facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of resident property, freedom from corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat a resident's medical symptoms. This facility therefore prohibits mistreatment, exploitation, neglect, or abuse of its residents, and has attempted to establish a residents sensitive and resident secured 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. abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents. (B)	S9999		

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