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S 000	Initial Comments Facility Reported Incident of 3/26/24/IL172868 Facility Reported Incident of 4/28/24/IL172869 Facility Reported Incident of 4/30/24/IL172870	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210c) 300.1210d)3) 300.1210)d)6) 300.3240e) 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	S9999		

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S9999	Continued From page 1 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. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 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 300.3240 Abuse and Neglect e) When an investigation of a report of suspected abuse of a resident indicates, based	S9999		

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S9999	Continued From page 2 upon credible evidence, that another resident of the long-term care facility is the perpetrator of the abuse, that resident's condition shall be immediately evaluated to determine the most suitable therapy and placement for the resident, considering the safety of that resident as well as the safety of other residents and employees of the facility. (Section 3-612 of the Act) These requirements were not met as evidenced by: Based on interview and record review, the facility failed to ensure that residents were free from physical abuse and failed to supervise residents on the smoking patio. These failures affected R2, R3, R5, R7 and R9 as a result of R2 who was physically hit in the head with a chair by R1, causing R2 harm of pain and a facial laceration by the right eye; R7 who was physically hit in the face by R8, causing R7 psychosocial harm by feeling unsafe as a legally blind and wheelchair dependent resident in the facility; R5 who was physically pushed by R6, causing a right hand scratch; R9 who was physically hit in the face by R2; and R3 who was physically hit by R4 in the sample of 14 residents reviewed. Findings include: 1) On 5/15/24 at 9:33 am, when asked about an altercation with R1 on 3/26/24 on the smoking patio, R2 stated, "(R1) grabbed my chair, and (R1) hit me with it (chair)." R2 stated, "I (R2) had a cut on this eye, and it hurt me, really hurt me," pointing to R2's right eyebrow. R2's Face Sheet documents, in part, diagnoses of paranoid schizophrenia, type 2 diabetes	S9999		

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mellitus, chronic obstructive pulmonary disease, emphysema, cardiac pacemaker, cardiomegaly, atherosclerotic heart disease, idiopathic epilepsy, and auditory hallucinations.

R2's Minimum Data Set (MDS), dated 2/28/24, documents, in part, a Brief Interview for Mental Status (BIMS) score of 12 which indicates that R2 has moderate cognitive impairment.

On 5/14/24 at 10:38 am, when asked about an altercation that occurred with R2 on 3/26/24 on the smoking patio, R1 stated that the altercation was with R2 on the smoking patio at the first smoke break (7:00 am). R1 stated that R1 was holding R1's cup of hot coffee and walked down the corridor out onto the smoking patio where residents can sit or stand to smoke on the left side or the right side of the smoking patio. R1 stated that R1 walked to the open wicker chair in front of the "grid iron fence," so with R1's left hand, R1 grabbed the arm of the wicker chair to try to sit down when R2 grabbed the other arm of the chair. R1 stated that R1 used R1's right elbow on the iron fence to balance self which then R1's coffee poured out of the cup. R1 stated that R2 let go of the arm of the chair, and "I (R1) took the chair and swinged it around and hit (R2). I whacked (R2) in the back of the head and back." R1 stated, "I (R1) called over (V11, Smoke Monitor) because (V11) was not visible." R1 said that when V11 responded, V11 said, 'What's going on?' because "(V11) didn't see nothing." When asked about other residents that may have been witnesses to R1 and R2's altercation, R1 stated that R12 was there. This surveyor asked R1 to show surveyor the smoking patio, so R1 and surveyor walked out to the smoking patio during smoke break to observe the area where R1 and R2's altercation took place on 3/26/24.

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S9999	Continued From page 4 The black iron fence is observed as an internal gate, and the outer gate (enclosure) of the smoking patio is a chain link fence which is visible through with the left side of the smoking patio being closest to the street corner of the intersecting streets. R1's Face Sheet documents, in part, diagnoses of hereditary and idiopathic neuropathies; major depressive disorder, recurrent, severe with psychotic symptoms; hypothyroidism; bipolar disorder; anxiety disorder; schizophrenia; hypo-osmolality and hyponatremia. R1's MDS, dated 4/25/24, documents, in part, a BIMS score of 15 which indicates that R1 is cognitively intact. On 5/15/24 at 10:49 am, V10 (Social Services Assistant, SSA) stated on 3/26/24 "a little after 7:00 am," V10 was "on my way to work. I (V10) was in my car" driving west when V10 stopped at the street intersection adjacent to the facility. V10 stated, "I (V10) stopped at the stop sign. I glanced over and seen something going on between (R1) and (R2)." V10 stated that V10 looked at R1 and R2 on the smoking patio and had a "good view" due to V10 facing in that direction. V10 stated that V10 drove through the intersection and pulled up in V10's car and observed R1 and R2 "struggling at the gate." V10 stated that V10 could not enter through the external chain link fence (enclosure of the smoking patio), but "I (V10) see (R1) with chair and hitting (R2)." V10 stated that R1 was "lifting up chair and striking (R2)," and R2 was cowering down towards the ground while being struck with the chair as V10 visually demonstrated to this surveyor with bending motion down to try to cover head with arms.	S9999		

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On 5/14/24 at 1:16 pm, R12 stated that R12 has witnessed resident to resident fighting in the facility. When asked about the altercation between R1 and R2 on 3/26/24 on the smoking patio, R12 stated that it was on 3/26/24 at 7:00 am to 7:15 am at beginning of smoke break. R12 stated that R12 witnessed "(R2) get attached by (R1) and was fighting with the chair." R12 stated, "(R1) hit (R2) first."

R12's MDS, dated 4/16/24, documents, in part, that R12's BIMS score of 15 which indicates that R12 is cognitively intact.

On 5/14/24 at 11:52 am, V11 (Smoke Monitor) stated that on 3/26/24 around 7:00 am, V11 opened the smoking patio door for residents who could walk to go "for seating, and I (V11) gave them their cigarettes." V11 stated that V11 then went back down the corridor to the door because other residents "were calling me (V11)" to help bring the wheelchair residents through the smoking patio door. V11 stated that V11 then heard "chaos," and walked from the door, down the corridor, and sees where R1 and R2 were standing on the left side of the patio by the gate.. V11 stated that V11 did not witness R1 and R2's altercation, and R1 told V11 that R1 pulled the chair from R2 when R2 was trying to take the chair. V11 stated that R2 said that R2 fell and that R1 hit R2 with the chair.

On 5/15/24 at 9:42 am, V3 (Assistant Director of Nursing, ADON) stated that V3 responded to R1 and R2's altercation on 3/26/24 to the code white that was called during the "transition of shifts (night and day shifts)." V3 stated that V3 assessed R2 right after the incident, and "(R2) did have on scratch on (R2's) right side of the

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S9999	Continued From page 6 face by (R2's) right eye." On 5/15/24 at 2:29 pm, V14 (Activity Director) stated that the first smoke break daily is at 7:30 am, and all residents are allowed out via the one patio door. V14 stated that there are 2 smoke monitors who are supervising residents on the patio. V14 stated that the process for the smoke breaks is that the smoke monitors will bring out the residents in wheelchairs and assist residents with walkers first out to the patio, then the remaining ambulatory residents are allowed out. V14 stated that the 2 smoke monitors will then distribute smoking materials. V14 stated that one smoke monitor will be supervising one side (left side), and the other smoke monitor will be supervising the other side (right side). V14 stated that the 2 smoke monitors are stationed in the center of the left and right patios "to move smoke monitors where they can view everyone in the center of the patio." When asked the purpose of having 2 smoke monitors on the patio during smoke breaks, V14 stated, "To stop anything before it happened." Facility document for the final abuse investigation for R1 and R2, titled "Facility Incident Report Form" and dated 4/1/24, authored by V1 (Administrator), documents, in part, that this reportable event occurred on 3/26/24 at 7:30 am with description of occurrence: "Staff member reported that R1 and R2 had a physical altercation ... R2 have laceration to (R2's) right eye. R2 was evaluated for pain on the scale 1 - 10. R2 pain scale is a 5. R2 received pain medication as prescribed." V1 documents, in part, the occurrence resolution as: "Investigation has been completed ... R2 stated (R2) and R1 approach a chair on the patio, and they both was struggling to sit down in the chair. R2 stated R1	S9999		

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took the chair from (R2) and hit (R2) with the chair ... R1 stated that (R1) went to patio to sit down and R2 try to take (R1's) chair. R1 stated (R1) got the chair from R2 and hit (R2) with the chair. (V10) witnesses the incident and states (V10) saw a struggle at the gate. (V10) stated then (V10) saw R1 hit R2 with the chair ... Police was notified of incident."

Police report, titled "Victim Information Notice/ (City) Police Department" with date/time of occurrence of 3/26/24 at 7:15 am, documents, in part, the incident of "Battery" with the name of the victim as R2 with the perpetrator listed at R1.

On 5/15/24 at 1:09 pm, V1 (Administrator) stated that V1 is the abuse coordinator for the facility and is responsible for reporting and performing abuse investigations in the facility. V1 stated that V1 reviewed all of the resident, witness and staff statements to come to a conclusion if physical abuse did occur. When asked if physical abuse did occur between R1 and R2 on 3/26/24, V1 stated, "Yes. It was substantiated."

On 5/16/24 at 12:05 pm, this surveyor and V1 reviewed together the "Facility Incident Report Form" dated 4/1/24 for R1 and R2's final abuse report. When V1 was asked where did V1 receive the information of R2's facial laceration near right eye and R2's pain score with pain medication administered on 3/26/24 after being hit with a chair by R1, V1 stated, "I (V1) received it from (V3, ADON), and I looked myself. (R2) had a small laceration over (R2's) eyebrow. It was open to air. (V3) stated (R2's) pain level that morning when it happened. I assessed (R2) myself. That's why I charted it" in the abuse report. V1 stated that V1 is a Registered Nurse, RN. This surveyor informed V1 that with this

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S9999	Continued From page 8 surveyor's record review performed of R2's electronic medical record (EMR) documentation of progress notes (March 2024) and paper medication administration record (MAR, March 2024), no documentation is noted of R2's facial laceration near right eye and R2's pain score of 5 with whenever needed pain medication administered on 3/26/24 after being hit with a chair by R1. On 5/16/24 at 11:50 am, V2 (Director of Nursing, DON) stated that nurses are to document the pain assessment of the resident using the 0-10 pain scale, document pain medication administration and then document how effective the pain medication is. When this surveyor showed V2 the March 2024 MAR for R2, V2 was asked if V2 can explain why there is no documentation of R2's pain scale score of 5 and pain medication administered, V2 stated, "I (V2) cannot." When this surveyor showed V2 the progress notes dated 3/26/24 for R2 with no documentation for R2's facial laceration by right eye, V2 was asked if V2 can explain why there is no documentation in R2's electronic medical record, and V2 stated, "I cannot." V2 stated that it's the expectation that a nurse document a resident to resident physical altercation incident, including skin impairment, injuries or pain, and nurses "should have documented it in events." This surveyor showed V2 the "events" portion in R2's EMR, and no "event" is documented for R2 in 2024. Facility job description (undated) titled "Smoke Monitor" documents, in part, "Position Summary: The primary purpose of the Smoking Monitor is to provide each resident a safe smoking environment and is designated to meet the interests and wellbeing of each resident.	S9999		

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S9999	Continued From page 9 Responsibilities: 1. Monitor resident smoking to assure safety and security ... 8. Follow (facility's) policies and procedures. 9. Create and uphold an atmosphere of warmth, patience, enthusiasm, and a calm cheerful environment." 2) On 5/13/24 at 12:11 pm, R7 observed in R7's wheelchair in 1st floor dining room with head looking down. V7 (Certified Nursing Assistant, CNA) moved R7 (with R7's verbal permission) via wheelchair by wheeling R7 out of the dining room to speak with surveyor. When asked about an altercation with R8, 3 days ago on 5/10/24, R7 stated, "I (R7) got hit. I got hit in the face by (R8)." R7 stated that R7 was in R7's wheelchair in R7's room doorway waiting for V7 (CNA) to wheel R7 out for a smoke break, and R8 hit R7. R7 stated, "I (R7) am blind, and I can't see." R7 stated that R7 "felt the hitting" from R8 standing over R7 who was in a seated position in R7's wheelchair. When asked if R7 feels safe in the facility, R7 stated, "No. I (R7) don't feel safe. I can't walk. I can't get away when someone is standing over me hitting me. I can't go nowhere." R7's Face Sheet documents, in part, diagnoses of blindness one eye with low vision other eye, kyphosis, dependence on wheelchair, bipolar disorder, schizophrenia, hypertensive heart disease, atrial fibrillation, hyperlipidemia, dementia (unspecified severity) with agitation, osteoarthritis, and benign prostatic hyperplasia. R7's MDS, dated 2/1/24, documents, in part, that R7's vision is scored as 4 which is "severely impaired - no vision or sees only light, colors, or shapes; eyes do not appear to follow objects." R7's BIMS score is documented as a 5 which indicates that R7 has severe cognitive impairment.	S9999		

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On 5/16/24, V1 (Administrator) provided this surveyor with R7's MDS, dated 5/2/24, section GG, due to no section GG being present on R7's MDS, dated 2/1/24, per V1. R7's MDS (5/2/24) documents, in part, that R7's mobility device is a wheelchair.

On 5/14/24 at 10:29 am, R10 stated that R10 did witness a resident-to-resident physical assault on 5/10/24. R10 stated, "I (R10) was around the corner walking in the hallway by the elevator. It was right at their (R7 and R8's room) door. I saw (R8) hit (R7) in the head a couple of times with (R8's) hands. It was last Friday (5/10/24)." R10 stated that R7 was in R7's wheelchair and that R8 was in a standing position. R10 stated that R10 "hollered out" for help, and housekeeping staff responded.

R10's MDS, dated 5/1/24, documents, in part, that R10's BIMS score of 15 which indicates that R1 is cognitively intact.

On 5/14/24 at 11:08 am, V9 (Housekeeping, Floor Tech) stated that V9 was in the hallway mopping on 5/10/24 around 9:00 am when V9 heard R7 hollering, "(R8) hit me (R7). (R8) hit me." V9 stated that V9 immediately went to R7 and R8's room where V9 observed R7 in R7's wheelchair and R8 standing near R7. V9 stated that only R7 and R8 were in their room. V9 stated that V9 stood in between R7 and R8, and that R7 was again saying, "(R8) hit me (R7)." V9 stated that R8 then said, "I (R8) hit (R7). I want out of here. I will call the police myself." V9 stated that R8 proceeded to pull out R8's cellular phone and called the police R8's self saying, "I (R8) hit (R7). I want out of here. I am at (facility's name)," and gave the address of the facility.

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On 5/13/24 at 2:29 pm, V7 (CNA) stated that V7 is R7's regularly assigned CNA on the day shift and sometimes the evening shift. V7 stated that R7 is blind, is in a wheelchair, and calls out V7's name when R7 needs assistance or wants to be wheeled to another location, like the smoking patio. V7 stated that after breakfast meal on 5/10/24 when V9 alerted V7 that R7 was hit by R8, so V7 wheeled R7 out of the room away from R8 and wheeled R7 to the dining room to stay with V7. V7 stated that R7 said, "(R8) hit me (R7) across the face a couple of times." This surveyor asked V7, as V7 is with R7 in the dining room after being hit by R8, how was R7 feeling, and V7 stated, "(R7) was afraid. I kept (R7) in the dining room."

R8's Face Sheet documents, in part, diagnoses of bipolar disorder, disorganized schizophrenia, attention deficit hyperactivity disorder, insomnia, asthma, and suicidal ideations. R8's admission date to the facility is documented as 5/6/24, and R8's discharge date is documented as 5/10/24 to the hospital. R8 was not available to be interviewed.

On 5/15/24 at 10:49 am, V10 (Social Service Aide) stated that V10 interviewed R8 on 5/10/24 after altercation with R7 (before going to the hospital). V10 stated that R8 said, "I (R8) hit (R7). I want to go to jail."

On 5/15/24 at 11:32 am, V13 (Licensed Practical Nurse, LPN) stated that on 5/10/24, during the morning medication pass, V13 was told by V12 (Housekeeper) that R8 had hit R7, and V13 responded to R7 and R8's room where R8 said that R8 hit R7. When asked about R7's status, "(R7) is visually impaired, in a wheelchair. (R7)

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needs assistance to get around building escorted by CNA or nurse. Staff have to move (R7) in wheelchair. (R7) cannot see (R7's) surroundings. (R7) will ask who is there to know who is with (R7)."

In R8's Progress Note, dated 5/10/24 at 8:57 am, V13 (Licensed Practical Nurse, LPN) documents, in part, "(R8) seen physically abusing (R7), when asked if (R8) hit (R7), (R8) aggressively stated that (R8) did and actively called the police."

Facility document for the initial abuse investigation, titled "Facility Incident Report Form" and dated 5/10/24, authored by V1 (Administrator), documents, in part, that this reportable event occurred on 5/10/24 at 9:00 am between R7, who is blind in both eyes, and R8 with description of occurrence: "Staff member reported that (R7) and (R8) had a physical altercation."

On 5/15/24 at 1:09 pm, V1 stated that on the morning of 5/10/24, V1 received phone calls from several staff members about R7 and R8's physical altercation, and since V1 was not in the facility on 5/10/24, V1 endorsed to social services and nursing staff to collect witness statements from residents and staff about the altercation. V1 stated that V1 has reviewed the witness statements for the abuse investigation, and "After investigation, I (V1) came to a conclusion. I substantiated physical abuse. (R8) did not deny the allegation. (R10) saw it. (R8) committed battery. (R8) wanted to get out here to jail." V1 stated that V1 will submit the final abuse investigation report to the state agency at the end of 5 business days. When asked if R7, who is legally blind and wheelchair bound, considered vulnerable for abuse, V1 stated, "Of course, (R7)

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S9999	Continued From page 13 is in that group. (R7) is vulnerable for abuse." 3) On 5/14/24 at 11:46 am, R5 stated that on 4/28/24, R5 was in R5's room and was waiting to use the bathroom which is shared with R6 from the room on other side of the bathroom (a jack and jill bathroom). R5 stated, "(R6) is using the bathroom constantly" and that R6 "plays around with the water in the sink." R5 stated that R5 had to use the bathroom, knocked, and opened the shared bathroom door, and that R6 threw water at R5 and pushed R5's body back. R5 stated that in the process of R6 pushing R5, R6 cut R5's hand in between 2 fingers on R5's right hand which was bleeding. R5's Face Sheet documents, in part, diagnoses of chronic obstructive pulmonary disease, hypertensive heart disease, simple chronic bronchitis, asthma, dyspnea, atherosclerotic heart disease, hyperlipidemia, and anemia. R5's MDS, dated 2/28/24, documents, in part, a BIMS score of 15 which indicates that R5 is cognitively intact. On 5/14/24 at 1:12 pm, R13 who is R5's roommate stated that R13 was in their room on 4/28/24 but did not see the altercation between R5 and R6. However, R13 stated, "I (R13) heard them both (R5, R6) at the bathroom. I heard (R5) say, 'Don't throw that water.' I didn't see it. My (R13) curtain was closed." R13's MDS, dated 2/19/24, documents, in part, a BIMS score of 15 which indicates that R13 is cognitively intact. On 5/13/24 at 1:29 pm, V5 (LPN) stated that R5 is alert, oriented x 4 (person, place, time, and	S9999		

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situation), and walks independently in the facility. V5 stated that in the morning on 4/28/24, V5 responded to "the scene" (R5's room) where V5 visibly sees R5 with water on R5's face. V5 stated that R5 said, "He threw water on me (R5)," and that V5 sees R13 (R5's roommate). V5 stated that V5 asked R5 who threw water on R5, and R5 stated that it was R6 who threw the water and was in the shared bathroom. V5 stated that V5 observed a scratch on R5's hand by a finger and asked how it happened. V5 stated that R5 said, "(R6) pushed (R5)." V5 stated that R5 said that R6 had been in the bathroom repeatedly flushing the toilet, like 20 times, and that R5 asked R6 what R6 was doing because R5 had to use the bathroom. R5 said that R6 pushed R5 and that R5 "threw (R5's) hand up." V5 stated that V5 provided first aid to R5's hand scratch by cleansing it with normal saline and applying a dry dressing. V5 stated that R6 was no longer in the shared bathroom and was in the dining room where V5 asked about what occurred between R5 and R6, and R6 said, "I (R6) don't know. I don't know. I don't know."

On 5/14/24 at 1:08 pm, when asked about an altercation with R5 on 4/28/24, R6 stated that R6 "don't bother nobody." When asked if R6 was in the bathroom and R6 pushed R5, R6 stated, "I (R6) don't do nothing." When asked if R6 threw water on R5, R6 stated, "I (R6) don't bother nobody."

R6's Face Sheet documents, in part, diagnoses of polyneuropathies, hypertensive heart disease, atherosclerotic heart disease, cognitive social or emotional deficit following unspecified cerebrovascular disease, hyperlipidemia, schizophrenia, delusional disorders, and cerebral ischemia.

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R6's MDS, dated 4/1/24, documents, in part, that R6's BIMS score is 5 which indicates that R6 has severe cognitive impairment.

In R5's Progress Note, dated 4/28/24 at 11:36 am, V5 (LPN) documents, in part, "(R5) was pushed by another resident and scratched on (R5's) right hand. (V5) cleaned the right hand with (normal saline solution), pat dry, and applied a dry dressing."

In R5's Progress Note, dated 4/28/24 at 2:59 pm, V4 (SSD) documents, in part, "(V4) was made aware that (R5) was involved in a physical altercation where (R5) received aggression ... (R5) stated that (R6) through (threw) water on (R5) right before pushing (R5)."

On 5/15/24 at 1:09 pm, V1 stated that V5 informed V1 on 4/28/24 that R5 and R6 had an altercation by the bathroom where R6 pushed R5 who sustained a scratch on the hand. V1 stated that V4 (SSD) obtained R5's statement, and V1 interviewed R6 after R6 returned from the psychiatric hospitalization who said that R6 don't remember pushing R5. When asked about V1's conclusion of the altercation between R5 and R6 on 4/28/24, V1 stated, "(R5) had a scratch when (R6) touched or pushed (R5) or something. Physical abuse is substantiated, I (V1) would say that."

Facility document for R5 and R6's final abuse investigation, titled "Facility Incident Report Form" and dated 5/2/24, authored by V1 (Administrator), documents, in part, that this reportable event occurred on 4/28/24 at 9:00 am with occurrence resolution as: "Investigation has been completed. (R5) stated (R5) wanted to use the bathroom.

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(R1) stated (R5) inform (R6) that (R5) had to use the washroom. (R5) stated when (R6) came out of the bathroom, (R6) push (R5) ... (R5) stated (R5's) right hand was bleeding. (R5) stated (R6) scratch (R5) when (R6) pushes (R5) ... (R6) did not denied pushing (R5)."

4) On 5/14/24 at 10:49 am, R9 stated that on 5/3/24, R9 was in another room and that it was in the morning time. R9 stated that R9 walked out of R9's room into the hallway, and "(R2) hit me (R9) in my left eye" pointing to R9's left side of face near eye. R9 stated that R2 hit R9 in the hallway and that R9 "didn't do nothing to (R2)." R9 stated that R9 did not strike R2 back. When asked if there were other residents or staff around when R2 hit R9 on 5/3/24, R9 stated, "No."

R9's Face Sheet documents, in part, diagnoses of schizoaffective disorder, bipolar type, chronic obstructive pulmonary disease, type 2 diabetes mellitus, abnormalities of gait and mobility, muscle wasting and atrophy, heart failure, and hyperlipidemia.

R9's MDS, dated 3/5/24, documents, in part, a BIMS score of 7 which indicates that R9 has severe cognitive impairment.

On 5/15/24 at 9:33 am, when asked about an altercation on 5/3/24 with R9, R2 stated, "I (R2) didn't want no one to hold me back. I pushed (R9) and hit (R9) in the eye. I wanted to get by to go smoke."

On 5/14/24 at 2:15 pm, V12 (Housekeeper) stated that V12 was in the hallway near the smoking patio door and the north nursing station desk on 5/3/24 around 7:00 am and was having a

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general conversation with R9. V12 stated that V12 then walked down the hallway, and "when I came back into that vicinity, it was over." V12 stated that V12 did not witness the altercation between R2 and R9, but R9 was saying, "(R2) hit me (R9). (R2) hit me."

On 5/14/24 at 5:21 pm, V18 (LPN) stated that V18 was completing the night shift medication pass on 5/3/24 around 7:00 am, when V18 responded to an altercation that had occurred between R2 and R9 in the hallway. V18 stated that V18 did not witness it but did interview and assess both R2 and R9 afterwards. V18 stated that R9 said that R9 was hit in the face by R2, and that R2 said that R9 would not get out of R2's way.

In R9's Progress Note, dated 5/3/24 at 7:17 am, V18 (LPN) documents, in part, that "(R9) was hit by (R2) in the face, because (R9) wouldn't move from in front of (R2)."

On 5/15/24 at 1:09 pm, V1 stated that V1 was notified by several nursing staff members on the morning of 5/3/24 that R9 was hit by R2. V1 stated that V1 interviewed R2, R9, and staff that were working on 5/3/24 at 7:00 am for the abuse investigation. When asked about V1's conclusion of this incident between R2 and R9, V1 stated, "It's physical abuse. It was substantiated."

Facility document for R2 and R9's final abuse investigation, titled "Facility Incident Report Form" and dated 5/9/24, authored by V1 (Administrator), documents, in part, that this reportable event occurred on 5/3/24 at 7:20 am with occurrence resolution as: "Investigation has been completed. Upon interviews (R2) hit (R9) because (R9) did not move out of (R2's) way in the hallway."

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Facility policy, titled "Abuse Policy" and revised (10/2022) with reviewed date of 1/18/24, documents, in part: "This facility affirms the right of our residents to be free from abuse ... This facility therefore prohibits abuse ... In order to do so, the facility has attempted to establish a resident sensitive and resident secure environment ... This facility is committed to protecting our residents from abuse ... by anyone including ... other residents ... Definitions: ... Abuse means any physical or mental injury ... inflicted upon a resident other than by accidental means ... Physical abuse include hitting."

Facility policy, titled "Attachment J: Statement of Resident Rights" and undated, documents, in part: "No resident shall be deprived of any rights, benefits, or privileges guaranteed by law, the Constitution of the Stare (State) of Illinois, or the Constitution of the United States solely on account of his or her status as a resident of the (facility), nor shall a resident forfeit any of the following rights: (a) Resident rights: The resident has a right to a dignified existence ... (1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life."

5. On 5/13/24 at 12:24 PM, R3 stated that R3 remembered R4 coming up to R3 in the hallway on 4/30/24 in the morning. R3 stated, "(R4) began hitting me (R3) out of nowhere on my head. (R4) was grabbing my wrists too. I thought maybe (R4) was making a sexual advance towards me. I was trying to defend myself when the staff came."

On 5/13/24 at 12:28 PM, R3 stated, "I no longer feel safe in the facility. All of the people

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S9999	Continued From page 19 (residents) make me feel unsafe". R3's "Resident Face Sheet" documents in part the following diagnosis: Paranoid Schizophrenia, Hypertensive heart disease without failure, and Unspecified psychosis not due to a substance or known physiological condition. R3's Minimum Data Set dated 3/19/24 documents in part that Brief Interview for Mental Status (BIMS) Score is 13 indicating R3 is cognitively intact. Facility document for the final abuse investigation for R3 and R4, titled "Facility Incident Report Form" and dated 5/6/2024, prepared by V1 (Administrator), documents in part, "Investigation has been completed. (R3) stated (R3) was ambulating in the hallway and (R4) was talking to (R3) about things (R3) did not understand. (R3) stated that (R4) continue talking to (R3), and (R4) hit (R3) unprovoked." On 5/13/24 at 2:30 PM, V9 (Housekeeper, Floor Tech) stated that V9 was working on 4/30/24 and confirmed that V9 was the staff member who witnessed the altercation between R3 and R4. V9 stated that V9 witnessed R3 and R4 fighting in the hallway. V9 stated, "I (V9) immediately intervened to break up the two residents (R3, R4) and yelled for help. The residents could not tell me (V9) what they were fighting about. They both looked upset." On 5/13/24 at 1:35 PM, V5 (Licensed Practical Nurse, LPN) confirmed V5 was working on 4/30/24 and remembered the altercation. V5 stated that V5 responded to the incident due to the "code white" being called overhead. V5 stated that upon arrival to the hallway, "(R3) was shaking," and both R3 and R4 "were visibly upset".	S9999		

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On 5/15/24 at 11:28 AM, V4 (Social Services Director, SSD) stated that V4 responded to the code white for R3 and R4's altercation, but V4 did not witness the incident. V4 stated that V4 did speak with R3 afterwards who informed V4 that R3 walked by the nurses station in the hallway, and R4 hit R3.

In R3's Progress Note, dated 4/30/24 at 3:43 PM, V4 (SSD) documents in part, "(V4) was made aware by staff that (R3) was involved in a physical altercation where (R3) received aggression. (R3) presents to be aox3 (alert, oriented to person, place and time) and can verbalize (R3's) wants and needs with no issues. (R3) stated 'I was just minding my business and (R4) came up and started hitting me. I started to block (R4's) hits."

On 5/14/24 at 2:10 PM, R4 was observedsitting on the edge of the edge of the bed, rocking back and forth. R4 was observed responding to internal stimuli and talking to R4's self. When R4 was asked about the incident that occurred on 4/30/24 with R3, R4 stated "I (R4) am not going back to that damn hospital! You would be mad if blacks jumped you too!" R4 was unable to answer any further questions regarding the altercation.

R4's "Resident Face Sheet" documents in part the following diagnosis: Chronic Obstructive Pulmonary Disease, Unspecified psychosis not due to a substance or known physiological condition, Chronic Respiratory Failure with Hypoxia, Combined Systolic and Diastolic Heart Failure, Iron deficiency Anemia, Dietary Calcium Deficiency, Hypertensive Heart Disease with Heart Failure, and Chronic Viral Hepatitis C. R4's MDS dated 4/1/24 documents in part that BIMS

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S9999	Continued From page 21 Score is 12 indicating R4 has moderate cognitive impairment. On 5/15/24 at 12:38 PM, V1 (Administrator) confirmed V1 is the facility staff member who conducted the abuse investigation on 4/30/24. V1 stated that V1 was notified of the incident by V5. V1 stated, "I (V1) don't exactly know what happened. I was told by staff that (R4) had hit (R3) and initiated an investigation. On 5/15/24 at 12:50 PM, V1 stated that based on the facility's abuse investigation that V1 conducted for R3 and R4's altercation, "I (V1) was able to substantiate resident to resident physical abuse occurred during this incident." When asked about what are the effects on a resident when a resident experiences physical abuse in the facility, V1 stated, "It's an impact on their wellbeing and safety. Residents have the right to be free of abuse and neglect." Facility undated policy titled "Code White - Resident with Aggressive Behavior Policy," documents in part, "Purpose: To provide a safe environment for all residents and staff ... Procedure: 1. Announce overhead "code white" by any staff if you see resident with aggressive behavior/physical or verbal altercation between residents." (B)	S9999		