

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6001135</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/06/2017</b>
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NAME OF PROVIDER OR SUPPLIER  <b>FOREST CITY REHAB &amp; NRSNG CTR</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>321 ARNOLD AVENUE ROCKFORD, IL 61108</b>
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S 000	<p>Initial Comments</p> <p>Complaint 1712868/IL93990 - F201, F205, F309 &amp; F425</p> <p>Complaint 1712936/IL94057 - F201, F205, F309 &amp; F425</p>	S 000		
S9999	<p>Final Observations</p> <p>Statement of Licensure Violations:</p> <p>300.610a) 300.620a) 300.1210b) 300.1630d) 300.3240a) 300.3300e)1)2)3)4)5) 300.3300g)</p> <p>Section 300.610 Resident Care Policies</p> <p>a) The facility shall have written policies and procedures, governing all services provided by the facility which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting.</p>	S9999	<p><b>Attachment A</b></p> <p><b>Statement of Licensure Violations</b></p>	

Illinois Department of Public Health  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

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S9999	<p>Continued From page 1</p> <p>Section 300.620 Admission, Retention and Discharge Policies</p> <p>a) All involuntary discharges and transfers shall be in accordance with Sections 3-401 through 3-423 of the Act.</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</p> <p>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.</p> <p>Section 300.1630 Administration of Medication</p> <p>d) If, for any reason, a licensed prescriber's medication order cannot be followed, the licensed prescriber shall be notified as soon as is reasonable, depending upon the situation and a notation made in the resident's record.</p> <p>Section 300.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)</p> <p>Section 300.3300 Transfer or Discharge</p>	S9999		
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S9999	<p>Continued From page 2</p> <p>e) For transfer or discharge made under subsection (d), the notice of transfer or discharge shall be made as soon as practicable before the transfer or discharge. The notice required by subsection (d) of this Section shall be on a form prescribed by the Department and shall contain all of the following:</p> <p>1) The stated reason for the proposed transfer or discharge; (Section 3-403(a) of the Act)</p> <p>2) The effective date of the proposed transfer or discharge; (Section 3-403(b) of the Act)</p> <p>3) A statement in not less than 12-point type, which reads:</p> <p>"You have a right to appeal the facility's decision to transfer or discharge you. If you think you should not have to leave this facility, you may file a request for a hearing with the Department of Public Health within 10 days after receiving this notice. If you request a hearing, it will be held not later than 10days after your request, and you generally will not be transferred or discharged during that time. If the decision following the hearing is not in your favor, you generally will not be transferred or discharged prior to the expiration of 30 days following receipt of the original notice of the transfer or discharge. A form to appeal the facility's decision and to request a hearing is attached. If you have any questions, call the Department of Public Health at the telephone number listed below."; (Section 3-403(c) of the Act)</p> <p>4) A hearing request form, together with a postage paid, preaddressed envelope to the</p>	S9999		
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S9999	<p>Continued From page 3</p> <p>Department; and (Section 3-403(d) of the Act)</p> <p>5) The name, address, and telephone number of the person charged with the responsibility of supervising the transfer or discharge. (Section 3-403(e) of the Act)</p> <p>g) A copy of the notice required by subsection (d)(1) of this Section and Section 3-402 of the Act shall be placed in the resident's clinical record and a copy shall be transmitted to the Department, the resident, the resident's representative, and, if the resident's care is paid for in whole or part through Title XIX, to the Department of Healthcare and Family Services. (Section 3-405 of the Act)</p> <p>These Regulations were not met as evidenced by:</p> <p>Based on observation, interview and record review, 1) the facility failed to ensure the requirements for involuntary discharge were met. These failures resulted in residents being displaced to facilities that could not meet their specialized needs such as attending activities/groups to promote independence and peer socialization. 2) the facility failed to provide and/or implement effective interventions for known behaviors to maintain residents highest mental and psychosocial well being. These failures contributed to residents exhibiting adverse behaviors towards others. These failures also resulted in residents being displaced for varying periods of time to more restrictive environments.</p> <p>3) the facility failed to have available and</p>	S9999		
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S9999	<p>Continued From page 4</p> <p>administer as needed medication for a resident exhibiting escalating behaviors. This failure contributed to R1 physically assaulting staff, being involuntarily discharged from his home and having criminal charges filed.</p> <p>This applies to 4 residents (R1, R3, R4 and R6) reviewed for involuntary discharges.</p> <p>The findings include:</p> <p>1. R1 has diagnoses to include but not limited to Schizoaffective Disorder, Major Depressive Disorder, Intellectual Disabilities, Obsessive Compulsive Disorder and Fragile X Chromosome according to the the electronic diagnosis list. The MAR (Medication Administration Record) dated May 2017 showed R1 had medication orders that included Olanzapine (antipsychotic) 20 mg at bedtime for Schizoaffective Disorder and Chlorpromazine (antipsychotic) 50 mg PO (orally) or IM (intramuscular injection) every 8 hours PRN (as needed) for agitation related to Schizoaffective Disorder. These orders were obtained and implemented on November 27, 2104 and May 26, 2015 (respectively) according to the electronic Medication Review Report printed May 17, 2017.</p> <p>On May 17, 2017 at 1:00 PM, R1 was observed lying in a small room in the local hospital emergency department. R1 was lying on a bed watching television. R1 would get out of the bed and ambulate in the emergency department hallways while squeezing a foam star (used for stress relief.) R1 ambulated on the balls of his feet with a limp to his gait. R1 would begin walking towards the exit doors and was easily redirected by the hospital staff. R1 was dressed</p>	S9999		
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S9999	<p>Continued From page 5</p> <p>in a hospital gown and gripper socks rather than his regular clothing. R1 was calm and cooperative but spoke in a child like manner. R1 said "(facility name) put me in a police car and brought me here (hospital). R1 said he "hit someone at (facility name)." R1 said "It was morning about 9:30-10:00 (AM) just before the coffee time. E17 (physical therapy) was getting on my nerves because they were trying to make me do exercises and I refused. She (E17) said she would put on my chart that I refused and I got angry because I didn't want it to be there (on the chart)." R1 said he doesn't really like it at the facility because they "yell at me, steal from me and are mean to me." R1 said "That morning (May 9, 2017) I gave the middle finger to a staff member when I was going to get coffee. She pi**ed me off and I told her to leave me alone. I went to (E4's - Psychosocial Rehabilitation Services Director - PRSD) office and talked awhile. E4 was pi**ing me off so I told her to leave me alone I was going to my room." R1 said "I told those a**holes to leave me alone." R1 said "I kicked (E11 Psychosocial Rehabilitation Services Counselor - PRSC) in the knee. Sometimes I have hit staff in the past. My dad came to see me that day (May 9, 2017) and told me they didn't want me back. I don't feel good about that." R1 had no furniture other than the bed and hospital overbed table. R1's lunch meal was on the overbed table. R1 stated he ate in this room while at the hospital and not in the dining room as he had done at the facility.</p> <p>On May 17, 2017 at 1:15 PM, Z10 (Center for Mental Health Manager) stated the facility has brought residents to the hospital emergency department before using the involuntary discharge. Z10 said placement is difficult and they don't qualify for acute care of the hospital</p>	S9999		
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S9999	<p>Continued From page 6</p> <p>and it can become a prolonged process. Z10 said R6 was brought to the hospital a year ago in the same manner as R1. Z10 said R6 was housed in the acute setting for 315 days before placement could be found. Z10 stated it has been her experience working in long term care facilities that discharges seem to depend on "who" is hit at the facility. Z10 said if administrative staff get hit, the residents are involuntarily discharged on an emergency basis.</p> <p>On May 17, 2017 at 1:30 PM, Z8 (Emergency Room Physician) said the sending facility reported R1 was aggressive. Z8 said the facility immediately told the Hospital Emergency Room staff they would not accept R1 back to the facility. The facility then sent staff back to the emergency department to serve R1 with a notice that said R1 had 24 hours to find somewhere else to live. Z8 said R1 is mentally unable to care for himself. Z8 said the facility did not express to the hospital what needs the facility could no longer provide. Z8 said "We (hospital) ruled out any medical conditions that could be affecting (R1's) behavior, such as a UTI (urinary tract infection). Everything came back fine medically so we called the facility to inform them we were sending him back. They refused to take him." Z8 said sometimes long term care facilities will bring residents to the emergency department and say they won't take them back but when the facilities are reminded it is illegal to "dump" residents, the facility will usually come back and pick up the residents. Z8 said since R1's arrival, R1 had exhibited no aggressive behaviors. Z8 said since R1's mother is his POA (power of attorney) the hospital called her to come get R1 as he was being discharged. Z8 said R1's POA became upset and said he could not come home and she would file a restraining order to prevent this from occurring.</p>	S9999		

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S9999	<p>Continued From page 7</p> <p>Z8 said R1 is too intellectually disabled to be discharged to the streets so he has been kept in the emergency room. Z8 said she is not aware of any needs R1 requires that could not be met by the long term facility. Z8 said R1 has no ability to obtain housing, has self care deficits, can't hold a job, can't be responsible for finances and has Fragile X Syndrome which affects intellectual development. Z8 said "An emergency department is to rule out life threatening and emergent conditions that need to be addressed within 24 hours. We can not meet long term care needs." Z8 said R1 has not exhibited any aggressive behaviors since his being brought to the emergency department 8 days ago.</p> <p>On May 17, 2017 at 2:00 PM, E6 (Activity Aide) said the facility has a daily "Coffee Clutch" at 10:00 AM and 2:00 PM. E6 stated R1 typically attends both groups as well as the 1:30 PM library activity. E6 said R1 was the first in line for the 10:00 AM group on May 9, 2017 and was not exhibiting any unusual behavior. E6 said R1 asked her if she wanted to see something funny and then "flipped me off." E6 said "I took it as a joke because he was not aggravated at all." E6 said about 10:15 AM, R1 came up to her and apologized repeatedly saying "I'm sorry." E6 said after R1 repeated his apology several times he asked her to remove his name from the 1:30 PM library time. E6 said she thought his asking to be removed was a little "strange" because he always attends. E6 said she looked at the list and R1's name had already been removed. E6 said R1 then began to repeat, "take me off the list!" E6 said at that point she realized R1 was becoming agitated and so she walked him over to E4's PRSD (Psychosocial Rehabilitation Services Director) office to deal with his escalating behavior.</p>	S9999		
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S9999	<p>Continued From page 8</p> <p>On May 17, 2017 at 11:20 AM, E4 said on May 9, 2017, R1 was seated in her office because he was upset with something that happened in the morning activities. E4 stated R1 was rocking back and forth and shaking his head which is what he does when his behavior is escalating. E4 stated she attempted to get R1 to discuss what was upsetting him but he refused to speak. E4 said she let R1 sit in her office, as it was a calm environment, as she continued to work. E4 said eventually R1 stood up and punched a bookcase in her office and left to go to his room. E4 said she followed R1 to his room and asked R8 (R1's roommate) to go tell the nurse to bring R1 his PRN medication to decrease R1's "chance of exploding." E4 said, E7 LPN (Licensed Practical Nurse) returned to the room without the medication and E4 did not know why.</p> <p>On May 18, 2017 at 10:00 AM, E7 LPN (Licensed Practical Nurse) said she was not R1's nurse on May 9, 2017 but went down the hallway to the room where R1 was residing because she heard loud voices. E7 said E4 and R1 were in his room, alone. E7 said R1 was lying on his bed shaking his head from side to side but easily redirectable. E7 said E4 was sitting on R1's bed. E7 said R1 was calm at that time but E4 told E7 to get R1 his PRN medication (Chlorpromazine.) E7 said she left to obtain the medication and could not locate it. E7 said she checked the convenience box medications and no Chlorpromazine was available. E7 said she was gone less than 5 minutes and then she returned to the room to inform E4 the medication was not available. E7 said by the time she returned to R1's room, E4 and R1 were in the hallway and E4 said R1 hit her. E7 said R1 was still easily redirectable as she locked arms with him and lead him back into</p>	S9999		

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S9999	<p>Continued From page 9</p> <p>his room. E7 said about that time a couple of PRSC's (Psychosocial Rehabilitation Services Counselors) had arrived to R1's room so E7 left. E7 said she couldn't imagine what happened in the 5 minutes she was gone. E7 said perhaps E4 and R1 had words. E7 said if E4 told R1 she was sending him "out" (to hospital or elsewhere), that "would have set him off." E7 said "I am guessing that is what happened, that she (E4) escalated (R1)." E7 said she went to E8 LPN (R1's nurse May 9, 2017) to inform her of the situation and the lack of medication availability. E7 said she and E8 searched for the Chlorpromazine and E8 validated there was none available in the facility.</p> <p>The nursing progress notes dated May 7 and May 8, 2017 showed R1 "refused" his Olanzapine for both days. No notes notifying the physician of the missed doses was documented until May 8, 2017. The nursing progress note read, "Note left for (ANP - Advanced Nurse Practitioner) in regards to (R1) refusing his HS (bedtime) Olanzapine." R1's care plan for a "history of exhibiting physically and verbally aggressive behavioral symptoms when he is agitated as evidenced by hitting staff...", initiated September 15, 2014 lists the intervention of identifying maladaptive behaviors before they become aggressive and encourage the use of PRN medications.</p> <p>On May 18, 2017 at 10:15 AM, R9 stated he was roommates with R1 for a long time. R9 said he was not in the room when R1 became upset about a week ago. R9 said he was not allowed down the wing during the event. R9 said "I heard that he hit someone." R9's MDS dated April 10, 2017 showed R9 as having no cognitive deficits.</p>	S9999		
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S9999	<p>Continued From page 10</p> <p>On May 18, 2017 at 10:15 AM, E10 PRSC (Psychosocial Rehabilitation Services Counselor) stated he was not aware of any issues on May 9, 2017 until E11 (PRSC) came to him and told him R1 was having an "episode" by his room. E10 said he went to the hallway where R1 lives and saw E4 and E5 LPN (Licensed Practical Nurse - MDS [Minimum Data Set] Coordinator) standing in the hallway with R1. E10 said R1 was yelling and swinging his arms but he did not witness R1 hit anyone. E10 said E5 left and R1 walked into his room and laid on his bed. E10 said at that point, E4 called out for someone to call 911. E10 said R1 got up out of bed and began repeatedly yelling "No don't call! I don't want to go!" E10 said R1 was arrested when he was about 18 years old so he knows what 911 means. E10 said, "I feel if (E4) had not said she was calling 911 in front of (R1), he would not have escalated to that point." E10 said R1 began yelling at E4 to get out of his room. E10 said then R1 threw a water bottle at E4 and tried to run out of the room. E10 said at that point, he and E11 used a bear hug technique to put R1 on the bed.</p> <p>On May 18, 2017 at 10:15 AM, E10 said he quit working at the facility a few days after R1's event of May 9, 2016 because he felt the management staff were unprofessional and did not handle R1's situation correctly. E10 said R1 has a history of physically abusive behavior and has even hit E10 in the past. E10 said he felt the only reason R1 was involuntarily discharged was because this time R1 hit E4 (management) instead of line staff.</p> <p>On May 18, 2017 at 1:15 PM, E11 (PRSC) stated she was in the dining room for lunch when she was approached by a CNA (certified nursing assistant) who told her there was a problem in the hallway. E11 said she stepped into the hallway</p>	S9999		
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S9999	<p>Continued From page 11</p> <p>and saw E4 and R1. E11 said she did not notice any hitting or swinging or arms but knew R1 was upset because he was rocking back and forth. E11 explained that is a self soothing behavior exhibited by R1 when he becomes upset. E11 said E4 was yelling down the hall for "someone to call 911." E11 said R1 is afraid of the police and he definitely heard E4 yell "call 911." This is when R1 threw a water bottle at E4. E11 said she never saw R1 hit E4. E11 said R1 stomped on her foot and kicked her shin during the side body hug take down on May 9, 2017. E11 said the first time R1 hit her was approximately 2 years ago. E11 said R1's behavior "cycles." E11 said R1 escalates then calms down. E11 said his escalating behavior usually "burns out" in 30-45 minutes. E11 said R1 has been sent to the hospital many times for behaviors but returns the the facility calm and no interventions were done. E11 said R1 is afraid of going to the hospital but more afraid of the police so typically if he is sent to the hospital for evaluation, he is calmed down by the time he arrives to the emergency room. E11 said she saw no difference in this episode as compared to any of his past behaviors. E11 said E9 (Housekeeping Director) was called to assist after she and E10 placed R1 on the bed because E9 gets along very well with R1. E11 said E9 was able to calm R1 enough that by the time the police arrived, R1 would have been fine to stay in the facility. E11 said at that point, he probably would have even take an oral PRN medication if the nurse wanted him too. E11 said in the past, R1 has calmed rapidly when his PRN medication is given. E11 said many times R1 will take it orally if offered because he would rather take it than have "a shot." E11's account of the events involving R1 on May 9, 2017 were consistent with E10's interview.</p>	S9999		
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S9999	<p>Continued From page 12</p> <p>On May 18, 2017 at 2:40 PM, E9 stated he was paged to assist with R1 on May 9, 2017. E9 said he has a good rapport with R1. E9 stated R1 has exhibited these behaviors in the past but he calms down quickly. E9 said "I have dealt with him a lot when he is like this." E9 said he and E10 sat on the bed with R1 for between 2-4 minutes and he was calm. E9 said R1 asked if he could go to the bathroom and E9 said he could and if R1 stayed calm he would sit on the bed across from him instead of next to him. R9 said he returned calm and they sat across from each other talking for about 7-10 minutes before the police arrived. R9 said R1 was calm and quiet the entire 9-14 minutes and left with the police quietly. E9 said "I felt his escalating behavior was over."</p> <p>On May 19, 2017 at 4:35 PM, Z9 (Hospital Psychiatrist) stated the events of May 9, 2017 at the facility will have "permanent psychosocial harm" for R1. Z9 said "anyone kicked out of their home of 6 years and threatened to be arrested is detrimental especially with (R1's) mental and emotional developmental delay." Z9 stated R1 has the mentality of approximately a 4 year old. Z9 said early signs of R1 becoming agitated include him talking about superhero's and bad guys (good vs evil), his tone will become louder and he will begin to pace and increase self-talking. Z9 said had staff intervened at the facility when R1 was at this point, he likely never would have become physically aggressive. Z9 said R1's PRN Chlorpromazine should have been given prior to him getting to the point of having rocking back and forth behaviors. Z9 stated R1 has not exhibited any aggressive behaviors since his arrival to the hospital 10 days ago. Z9 said he would expect staff to notify the physician if a resident misses 1 dose of an antipsychotic. Z9</p>	S9999		
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S9999	<p>Continued From page 13</p> <p>said that if "2-3 doses of Olanzapine are missed," there is an increased potential for a resident to exhibit increased behaviors. Z9 said an IM medication would have been appropriate to use, "without question" even if the resident was agitated. Z9 said if PRN medications are ordered it is expected they would be used when needed. Z9 said an IM Chlorpromazine would have been effective in 30 minutes or less as it is very sedating. Z9 said the medication in the IM form works rapidly.</p> <p>On May 19, 2017 at 9:56 AM, an interview was conducted with Z7 (Facility Psychiatrist). Z7 stated he has never witnessed one of R1's "episodes." Z7 states he based his decision to have R1 involuntarily discharged on the reports given to him by the facility staff that R1's behavior was escalating. Z7 explained "(R1) used to take Clozaril (antipsychotic) as a PRN medication because it is most effective for treating psychotic aggression." Z7 said "R1 had a partial colon re-section and side effects of Clozaril is mega-colon so I had to discontinue the Clozaril and start him on something else." Z7 said the Clozaril was discontinued about 2 years ago and Chlorpromazine was ordered as the second best solution. Z7 stated giving R1 the ordered dose of PRN Chlorpromazine (antipsychotic) "theoretically" would of minimized his aggression but it "hasn't been working." Z7 then stated he was not made aware R1 had missed 2 consecutive doses of Olanzapine prior to the episode of May 9, 2017 and was not aware that the PRN medication was not being offered, given nor even available at the facility. Z7 said the IM Chlorpromazine would have been appropriate to be administered even if R1 was actively exhibiting aggressive behaviors.</p>	S9999		
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S9999	<p>Continued From page 14</p> <p>On May 19, 2017 at 11:30 AM, E3 ADON (Assistant Director of Nursing) stated the facility is linked to the pharmacy electronically. E3 said the pharmacy delivers medications to the facility 2 or more times daily during the week and at least daily on the weekends. E3 stated if a resident has an active PRN order, the medication should be available at all times. E3 stated the facility has no specific policy for obtaining Emergency Medications.</p> <p>The care plan for R1 with the focus area listed as Resident Diagnoses was initiated on August 23, 2016. In the focus section, the care plan showed R1 as exhibiting delusions regularly and lists an intervention of "Administration of psychoactive medications as ordered by physician." This care plan had no intervention revision dates since the initiation of the care plan. The care plan for R1 with the focus area listed as R1 "has a history of exhibiting physically and verbally aggressive behavioral symptoms as evidenced by hitting staff" was initiated on September 15, 2014. Interventions listed for this behavior includes "identify maladaptive behaviors before they become aggressive and encourage the use of PRN medication to help (R1) to calm down."</p> <p>The facility's Medication Administration Policy dated February 2017 showed "Medications must be administered in accordance with a physician's order. The list of convenience box medications provided by the facility showed no Chlorpromazine was available. The facility's policy titled Refill Orders updated December 31, 2014 showed "A supply of medications as ordered by the physician will be available to residents at all times."</p>	S9999		
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S9999	<p>Continued From page 15</p> <p>Review of the discharge paperwork titled "Notice of Involuntary Transfer or Discharge" showed R1 was sent to the local hospital emergency room and was not returning to the facility because "the safety of individuals in this facility is endangered." E3 and E4 stated during interviews on May 19, 2017 and May 17, 2017 (respectively) that they delivered R1's involuntary discharge paperwork to the hospital emergency department after R1 had been removed from the facility.</p> <p>On May 23, 2017 at 8:40 AM, Z4 (Long Term Care Ombudsman) said she has many concerns regarding this facility and the involuntary discharges. Z4 said, "They are dumping people at hospitals. It's pretty clear." Z4 stated R1 was eventually admitted to a room on the hospital's 4th floor because placement could not be found and he could no longer remain in the emergency room. Z4 said R1 had developmental disabilities in addition to his mental health diagnoses and can't just be thrown out of the facility.</p> <p>A hospital consultation note written by Z9 on May 12, 2017 showed "review of the medical record indicates patient (R1) presenting to the emergency department multiple times with similar complaints from (facility name)...At this time, (R1) does not meet criteria for acute psychiatric hospitalization."</p> <p>Hospital/Emergency Department progress notes since R1's arrival May 9, 2016 showed R1 has exhibited no aggressive behaviors. The notes showed R1 is cooperative and easily redirectable. The May 9, 2017 note at 4:49 PM showed R1 told the hospital staff he was not going to hurt anyone, that he was just mad (earlier) because "(E4) told</p>	S9999		
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S9999	<p>Continued From page 16</p> <p>him he was going to jail."</p> <p>The facility census sheet showed R1 was initially admitted to the facility on July 12, 2011 making him a resident of the facility for almost 6 years. The August 16, 2016 social service note of 10:26 AM, showed R1 was placed on a 1:1 (one staff member to care for R1 only) and an involuntary petition was completed and R1 was sent out to the local hospital to be evaluated for exhibiting aggressive behaviors to include throwing chairs, attempting to hit staff, and making threats to himself and his parents. The Nursing progress note dated August 16, 2016 at 10:30 PM showed R1 returned from the hospital emergency department and was accepted back into the facility with no behaviors being exhibited. The November 16, 2016 at 4:18 PM and February 13, 2017 at 3:50 PM social service notes showed R1 "hasn't exhibit(ed) any incidents of aggressive behaviors during this quarter and his mood status remains stable." The January 3, 2017 Psychiatry Note timed 8:02 PM showed R1 "is stable." On March 7, 2017 at 11:24 AM, a social service note showed R1 "was very agitated and aggressive...threw a table...an involuntary petition was completed and (R1) will be sent to the ER (emergency room) for a psych evaluation." The nursing note dated March 7, 2017 at 6:27 PM showed R1 was again returned and accepted back to the facility with no new orders and displaying appropriate behaviors. Screening Assessment for Indicators of Aggressive and/or Harmful Behaviors are completed quarterly on all residents by the social services department. R1's assessments completed between February 22, 2016 and February 13, 2017 showed no changes in R1's risk level. All assessments identified R1 as "Potentially able to integrate with structure, direction, and supportive counseling." All</p>	S9999		
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S9999	<p>Continued From page 17</p> <p>progress notes to include physician, nurse practitioner, psychiatrist and psychologist for R1 for the past year were requested. All records/notes provided were reviewed with no mention made of difficulties or changes in mood/behavior documented until May 9, 2017.</p> <p>R1's care plan for a "history of exhibiting physically and verbally aggressive behavioral symptoms when he is agitated as evidenced by hitting staff...", initiated September 15, 2014 lists interventions to include: avoid over-stimulation (e.g. noise, crowding); avoid power struggles with resident; identify maladaptive behaviors before they become aggressive and encourage the use of PRN medications; try not to reason with or confront the resident; and when resident becomes physically abusive, keep distance between resident and others (e.g. staff, other residents, visitors).</p> <p>The facility's policy dated March 2017 titled Behavior Crisis showed protocol is to diffuse crisis through calming communication and assess the need for chemical restraint.</p> <p>During the daily status meeting on May 19, 2017 at 3:30 PM, E1 (Administrator), E3 ADON (Assistant Director of Nursing), E4 (PRSD), E5 LPN (MDS Coordinator), E19 &amp; E20 (Corporate Nurses) were asked why R1 was not returned to the facility once he was stabilized at the hospital and a 30 day discharge notice initiated. There was no explanation/response as to why R1 was not allowed to return to the facility.</p> <p>2. R6 was a resident at the facility from March 23, 2010 to May 19, 2016 according to the facility census sheet. The facility provided a prescreening assessment for R6 dated June 26,</p>	S9999		
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S9999	<p>Continued From page 18</p> <p>2008. The prescreening assessment lists the following: Physical Violence towards others = moderate. Recently twisted his father's arm and hit another client in January 2007; Poor Judgement placing self or others at risk = High. Poor self care, no insight into his delusions, may be putting others at risk; Serious wandering elopement risk = Moderate; and Sexual Aggression = High. R6 has expressed sexually inappropriate behaviors.</p> <p>A nursing note dated May 20, 2016 at 4:20 PM, describes R6 exhibiting inappropriate sexual behaviors with peers. At 7:47 PM, the nursing note showed R6 was sent to the local hospital emergency department for a psychiatric evaluation. At 10:00 PM, the nursing notes showed a call was received from the local hospital emergency room stating that R6 was medically cleared and needed to return to the facility. Facility social service progress notes document attempts to locate alternative placement was being sought. A nursing note dated May 22, 2017 at 1:33 AM, (over 2 days after R6 was cleared to return to the facility), the emergency department again contacted the facility and stated R6 was cleared and needed to return to the facility. The progress note (authored by E18 Registered Nurse), showed E18 stated he would not accept R6 back to the facility.</p> <p>On May 30, 2017 at 11:30 AM E4 said R6 was sent to the local hospital emergency department due to inappropriate sexual behaviors. E4 said R6 was not involuntarily discharged. E4 said she had made arrangements for R6 to be transferred to (another facility). E4 said the new facility was supposed to work with the hospital for a direct admit from the emergency room to their location. E4 said the hospital called their facility at 1:00 AM</p>	S9999		
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S9999	<p>Continued From page 19</p> <p>and the nurse said he wouldn't take R6 back due to the time of the day/night. E4 said "I don't know why our nurse didn't explain R6 was set to go to (another facility). E4 said the local hospital never relayed to her or their facility that the (other facility) was no longer an option for R6.</p> <p>On May 19, 2017 at 4:35 PM. Z9 (Hospital Psychiatrist) stated this local long term care facility sent R6 to their hospital with severe to profound mental disabilities, a PEG (Percutaneous Endoscopic Gastrostomy) tube and incontinence of stool. Z9 said R6 had lived at the facility for 4 years and came to the hospital in the same way as R1. Z9 said R6 was listed as his own guardian and could not make his own decisions. Z9 said R6 needed Mental Health services not psychiatric services. Z9 said R6 was eventually admitted to the hospital acute psychiatric facility and was a patient for just shy of 1 year. Z9 said due to the hospital being an acute psychiatric facility, they (the hospital) did not have the resources available to obtain mental health placement for R6. Z9 said R6 is now in a Group Type home and functioning much more independantly with the services that were not available to him at the hospital.</p> <p>3. R3 was admitted to the facility on July 8, 2016 according to the facility census sheet. R3's psychiatric progress note dated July 12, 2016 showed "staff report stable mood and psychotic symptoms." R3's diagnoses included but were not limited to Anxiety Disorder, Dementia with Behavioral Disturbances, Unspecified Psychosis, and Homicidal Ideations according the the facility's electronic diagnosis list. The facility care plan initiated July 18, 2016 showed a focus area of "Resident has diagnoses that include Bipolar Disorder, Psychosis, and Homicidal</p>	S9999		

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S9999	<p>Continued From page 20</p> <p>Ideations."The September 5, 2016 psychiatric progress note showed R3 "has exhibited no aggressive episodes since admission to the facility." The January 3, 2017 psychiatric progress note showed R3 "with continued stable mood symptoms, no acute changes."</p> <p>A December 5, 2016 social service note showed R3 "had (an) altercation with staff during lunch... (R3) became agitated and began swearing at staff...was redirected." The January 10, 2017 social service note showed R3 has verbal confrontations with others. A January 13, 2017 social service note showed R3 "took a full cup of water and threw it on a peer as he was angry that the peer spilled (R3's) apple juice." A January 30, 2017 social services note showed R3 had been asking to have homicidal ideation removed from his diagnoses list. This social service note showed Z12 (Psychologist) was informed of R3's request and stated "due to (R3's) ongoing physical and verbal aggressive behaviors since his admission to this facility, she does not feel it's appropriate to remove the diagnosis at this time." A February 28, 2017 social service note showed R3 "has a history of being verbally aggressive towards his peers when he is agitated or angry."</p> <p>There was no documentation provided that R3 had ever been involuntarily discharged for these documented behaviors.</p> <p>The nursing progress note dated March 3, 2017 at 10:16 AM showed housekeeping staff alerted the nurse that R3 was on the floor. The note showed R3 stated he stumbled over his wheelchair and fell. Attempts to assess R3's right hip were unsuccessful and R3 was sent to the local hospital for a medical evaluation. The March 3, 2017 progress note of 10:18 AM showed a</p>	S9999		
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S9999	<p>Continued From page 21</p> <p>hospital nurse called the facility to make them aware R3 expressed having thoughts of hurting another resident at the facility. The nursing note of March 3, 2017 at 12:24 PM showed R3 was being admitted to the local hospital with a diagnosis of a fractured hip.</p> <p>A hospital emergency department note dated March 3, 2017 at 12:28 PM showed E13 RN (Registered Nurse - long term care facility) told the emergency department RN the facility "won't take (R3) back due to (his) threats against roommate."</p> <p>R3 was served with a notice of involuntary discharge on March 3, 2017, 3 days after sustaining a fractured hip. The reason listed on the discharge papers was "the safety of individuals in this facility is endangered."</p> <p>R3's care plan initiated October 7, 2016 showed a focus area of "manipulative behavior as evidenced by making statement of wanting to blow peers up, stating he has a plan to act 'crazy' so he can get kicked out of this facility, threatening to call IDPH (Illinois Department of Public Health), his insurance caseworker and local news stations to report the facility, etc." The interventions included educate R3 on the importance of using appropriate skills vs. making threats towards others and towards the facility; redirect; remind R3 inappropriate behavior will not be tolerated; and set clear limits for expected behavior.</p> <p>On May 30, 2017 at 11:05 AM, E4 stated R3 was transferred out due to a fall. E4 said the facility made the decision the day R3 was sent out for the fall not to accept him back to the facility. E4 said R3 was given the written notice of</p>	S9999		
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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S9999	<p>Continued From page 22</p> <p>Involuntary Discharge 1-2 days after he was sent to the hospital. E4 said no alternative living arrangements were offered prior to R3's discharge.</p> <p>On May 30, 2017 at 12:10 AM, E13 stated R3 was never physically aggressive while at the facility. E13 said R3 was easy to redirect and the only time he threatened to "kill" someone was at the hospital.</p> <p>4. R4's computerized diagnoses list includes but is not limited to disorganized schizophrenia and dementia with behavioral disturbance. R4's MDS (Minimum Data Set) dated January 9, 2017 shows behaviors including physically aggressive to others, verbally aggressive to others, and other behavioral symptoms not directed towards others. The same MDS under the Change in Behavior or Other Symptoms section (E1100) states: How does the resident's current behavior status compare to prior assessment? Same</p> <p>R4's computerized census sheet shows she has been a resident in the facility since March 2013 (almost 4 years).</p> <p>R4's care plans were reviewed and showed a focus area initiated dated October 9, 2014 which stated: (R4) has a history of physical aggression, which probably stems from her dementia and confusion. At times, (R4) becomes confused and delusional as a side effect of her ammonia levels. The care plan focus area also listed dates of R4's aggressive behaviors which included:</p> <p>November 5, 2015 (R4) pushed another pt (patient) to the floor February 23, 2016 (R4) displayed physical aggressive behaviors towards two residents</p>	S9999		
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S9999	<p>Continued From page 23</p> <p>February 28, 2016 (R4) threw a chair in the dining room</p> <p>July 13, 2016 (R4) attempted to hit a peer with wet floor sign</p> <p>July 15, 2016 (R4) pushed and hit staff</p> <p>August 16, 2016 (R4) pushed peer</p> <p>August 18, 2016 (R4) hit a female peer on the back of the head</p> <p>September 2, 2016 (R4) hit a female peer in the back</p> <p>R4's social service progress notes show additional incidents of aggressive behavior including:</p> <p>January 9, 2017 Patient (Pt) agitated today which she always is on money management days. Pt came behind staff trying to grab and hit staff</p> <p>November 13, 2016 hit a housekeeper</p> <p>October 27, 2016 hit roommate</p> <p>July 29, 2016 staff witnessed R4 throwing a chair in the upstairs dining room which struck a peer in the lower legs</p> <p>R4's care plans also showed a focus area initiated May 6, 2015 which stated: (R4) has complications with controlling mood swings. She needs reminders for interacting appropriately when agitated.</p> <p>R4's social service progress note dated January 21, 2017 at 9:27 AM states: This writer was informed that Pt. pushed a water cooler off of the first floor nurses's station, causing it to strike a female peer in the face .....nursing staff inspected (R4) for injury. None were noted.</p> <p>R4's social service progress note dated January 21, 2017 at 11:49 AM states: Pt had an aggressive incident this morning with a peer. Her</p>	S9999		
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S9999	<p>Continued From page 24</p> <p>peer called the police, the police came to the facility, gathered information, and arrested Pt for battery. Pt was taken via police to the (local county jail). Due to Pt's aggressive behavior, she will be given an Emergency Involuntary Discharge.</p> <p>R4's police report narrative dated January 21, 2017 stated: (resident hit by water cooler) advised she is sore, but does not have any visible marks and (R4) did not make any statements towards her prior to the incident or afterwards. (Police officer) did not observe injuries. She advised she would like to pursue charges. The police reports shows E10 (PSRC) stated resident had not been spoken to by social service staff before she had contacted the police. The report also shows police viewed the surveillance footage of the incident and stated R4 did push the water cooler off the counter, which did hit a resident. The report stated R4 was not stopped by staff and continued walking through the hallway. The police report stated he observed a CNA turn around to see what had happened, and then she turned back around to her desk. Police stated it was a "short time" before the CNA assisted the resident to another chair in the area. The report also states staff informed police R4 can be irrational in the morning if she has not received her medication. The report states the cooler incident occurred at 7:37 AM.</p> <p>The progress notes of the female peer struck with the water cooler was reviewed and showed a nursing progress noted dated January 21, 2017 stating: Resident assessed for injury after resident stated being hit in the face by a water jug. This writer saw no injuries on resident face. ROM (range of motion) extremities with no pain. A social service note of the same date states:</p>	S9999		

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S9999	Continued From page 25  She claimed that her nose was a bit sore, but did not wish for further attention.  On May 16, 2017 at 9:17 AM, Z4 (Ombudsman) stated she was notified on January 21, 2017 of R4's involuntary discharge to the local county jail and was concerned with the fact E4 (PSRD) had relayed to her that jail protocol prohibits the dispensing of medications and R4 was "locked up in a cell with 3 other people." Z4 stated R4's daughter bailed her out of jail the same day and took her to the local hospital. Z4 stated the facility was "using the pressed charges as a reason for an immediate discharge rather than a 30 day notice of discharge." Z4 said she spoke with the Public Defender's Office and R4's charges had been dropped the day of the incident.  On June 2, 2017 at 1:10 PM, Z13 (R4's daughter/POA) stated she bailed R4 out of jail around noon on January 21, 2017. Z13 said R4 was smiling, totally calm, not psychotic, and not aggressive. Z13 said she took R4 to (the local hospital) because she had nowhere else to go. Z13 state R4 needs 24 hour care and had no other choice but the hospital. Z13 stated the hospital called the facility repeatedly requesting R4 be admitted back in and the facility continued to refuse. Z13 said the hospital told the facility R4 was stable and able to be returned yet the facility still said no. Z13 said, "Yes, I did want her to go back. I had no other place to put her." Z13 said R4 sat at the local hospital from approximately noon until 11:00 PM and was calm the entire length of time. Z13 stated she was told by three separate staff members, E1 (Administrator), E4 (PSRD) and an Adapt staff member, that R4 was not allowed to return to the facility. R4 was finally transfered to a second facility. Z13 stated the hospital located, organized, and orchestrated	S9999			

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S9999	<p>Continued From page 26</p> <p>the entire transfer process (to an acute psychiatric facility.) Z13 stated the facility did nothing to assist the hospital with placement. Z13 stated she never stopped trying to get R4 back into the facility. Z13 said she had a meeting with R4's discharging facility sometime in February 2017 in an effort to have R4 readmitted. Z13 stated E4 (PSRD) was present during that meeting and was laughing, rolling her eyes, making huffing noises and "had an attitude." Z13 stated E4 was "playing on her phone the entire time" and was showing no interest in discussing R4's return.</p> <p>R4's involuntary discharge records show R4's daughter did file an Involuntary Discharge Hearing Request on January 21, 2017 (day of discharge). R4's medical record does not show any readmission to the facility after January 21, 2017.</p> <p>On May 18, 2017, E10 (PSRC) stated during meetings related to resident behavioral issues, upper management would disregard his concerns. E10 stated they (upper management) would always keep doing paperwork when he came in to discuss resident incidents and he felt like his concerns were not being addressed.</p> <p>On May 23, 2017 at 8:40 AM, Z4 (Long Term Care Ombudsman) said R4's charges were dropped but the facility still would not take her back.</p> <p>On May 30, 2017 at 11:15 AM, E4 (PSRD/Discharge Planner) stated R4 was arrested because she pushed a water cooler onto another resident. E4 stated the police "insisted" R4 be arrested and she was charged with</p>	S9999		
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S9999	<p>Continued From page 27</p> <p>assault, therefore was involuntarily discharged "because she was in jail." E4 stated R4 was bailed out of jail the same day (January 21, 2017) by family and taken to the local psychiatric hospital. E4 stated R4 was not allowed to return to the facility after the water cooler incident because she "was a danger" to residents. E4 stated R4 was not readmitted to the faculty after being released from jail or after stabilization at the local hospital. E4 said there were no alternative living arrangements offered to R4 prior to discharge or while in jail awaiting bail.</p> <p>On May 30, 2017 at 12:10 PM, E13 (Registered Nurse) stated R4 had a known history of being physically abusive to staff and throwing objects. E13 stated the January 21, 2107 incident "was not new behavior for her." E13 stated the cooler incident was a random act and not any different as in the past when (R4) got agitated. E13 said, "The cooler just happened to hit a resident who was close by at the time." E13 stated R4 has displayed similar behaviors in the past and could be easily re-directed. E13 stated there are currently several other residents residing in the facility with similar aggressive behaviors like throwing things or hitting.</p> <p>On May 17, 2017 at 12:10 PM, E5 (Licensed Practical Nurse) stated there are residents currently residing in the facility with similar safety concerns and named R13. E5 stated he does not know why R13 has been allowed to stay in the facility when other residents are discharged for similar type behavior. R13's medical record shows he currently resides in the facility and a social service progress note dated May 14, 2017 states: (R13) was involved in an altercation with another resident tonight during dinner ....(R13) lunged toward resident "A", the evening CNA</p>	S9999		
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S9999	<p>Continued From page 28</p> <p>reached for R13 to stop him from stabbing resident "A" with a fork.</p> <p>On May 17, 2017 at 1:00 PM, E7 (Licensed Practical Nurse) stated there are residents currently residing in the facility with similar behaviors and named R10. R10's medical record shows he currently resides in the facility. Social service notes dated January 16, 2017 shows he hit a member of the Adapt staff and January 13, 2107 he hit staff while they were trying to redirect him and almost struck another resident.</p> <p>On May 18, 2017 at 1:15 PM, E11 (PSRC) stated there are residents currently residing in the facility with similar behaviors and named R12. R12's medical record shows she currently resides in the facility. Social service notes dated May 18, 2017 shows she hit peer in the shoulder 4 times when peer attempted to take a dirty tray from her, March 21, 2016 she was blocking the way to a male peer. The male peer asked her to move aside and R12 got upset and hit him on the arm. August 15, 2015 SS observed pt taking food off the cart. Pt became agitated and grabbed and scratched the arm of SS. February 14, 2015, R12 slapped a CNA staff when they were trying to grab a cigarette that she was chewing. February 7, 2015, R12 began to kick, punch and swear at staff. December 12, 2014, R12 became agitated and hit CNA and also hit peer in the back of his head.</p> <p>(B)</p>	S9999		
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