STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000822	A. BUILDING: _____ B. WING _____	C 05/04/2021

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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
S 000	Initial Comments Complaint Investigation 2182202/IL132342 2182545/IL132794	S 000		
S9999	Final Observations Statement of Licensure Violations (Violation 1 of 2) 300.610a) 300.1035a)4) 300.1035a)5) 300.1210b) 300.1210c) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1035 Life-Sustaining Treatments a) Every facility shall respect the residents' right to make decisions relating to their own medical	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 treatment, including the right to accept, reject, or limit life sustaining treatment. Every facility shall establish a policy concerning the implementation of such rights. Included within this policy shall be: 4) procedures detailing staff's responsibility with respect to the provision of life-sustaining treatment when a resident has chosen to accept, reject or limit life-sustaining treatment, or when a resident has failed or has not yet been given the opportunity to make these choices; 5) procedures for educating both direct and indirect care staff in the application of those specific provisions of the policy for which they are responsible. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures: c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)	S9999		

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S9999	Continued From page 2 These requirements were not met as evidenced by: Based on interview and record review, the facility failed to perform life sustaining cardiopulmonary resuscitation (CPR) on a full code status resident who was unresponsive without breathing or a pulse and failed to notify emergency medical services (EMS) personnel for one (R1) of three residents reviewed. This failure affected R1 who was full code status, did not receive the required CPR and expired and has the potential to affect all 140 residents in the facility. Findings include: R1 was a 71 year old resident with diagnoses of cerebral infarction, epilepsy and type 2 diabetes. R1's Physician Order Statement (POS), dated 10/18/19, documents, in part, that R1's code status is a "Full Code." On 4/14/21 at 3:35 pm, V3 (LPN) stated she was R1's primary nurse on 3/2/21 for the 3:00 pm to 11:00 pm shift. V3 stated that on 3/2/21, she first observed R1 in a wheelchair when he was returning from an outside appointment around 4:00 pm and was accompanied by V6 (Certified Nursing Assistant in Training/CIT). V3 stated that V6 needed assistance getting R1 from the wheelchair back to bed and that "nothing seemed off" with R1. When this surveyor asked if R1 was alert at this time, she stated that R1 "was okay" when V3 and V6 transferred him from the wheelchair to the bed. V3 stated that R1 did say hello to her but did not "hold a conversation." V3 stated that after R1 returned from his outside appointment, she did check in R1's electronic medication administration record (EMAR) and	S9999		

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saw that the code status field in R1's EMAR did not display a full code or a DNR (Do Not Resuscitate). V3 stated, "I thought that (R1) was a DNR because of his decline and that he wasn't well for a while." V3 stated that she then began passing medications to residents down R1's hallway. V3 stated that at 5:00 pm, V6 and V12 (Certified Nursing Assistant/CNA) came out of R1's room, informing her that "something seems wrong with (R1)." V3 stated that she entered R1's room, along with V6 and V12, and that R1 was "not responsive and slumped over in the bed." V3 stated that he had a faint pulse when she assessed him and questioned whether R1 had agonal breathing but "didn't really see (R1's) chest move." V3 stated that she shook him and called his name, but R1 didn't respond. V3 stated that she went out to the hallway to her medication cart to get the electronic, wrist blood pressure cuff and pulse oximeter machine and returned to check R1' s vital signs. V3 stated that the blood pressure readings on both of R1's wrists registered as "error" and that she tried to obtain a reading on several of R1's fingers for his oxygen saturation levels and heart rate. V3 stated that no readings registered on the pulse oximeter machine. V3 stated that she went out of R1's room to the hallway to ask for help from V7 (LPN) by telling her that she couldn't get any vital signs for R1. V3 stated that she and V7 made an assessment of R1 by checking for carotid and brachial pulses and for active breathing. V3 stated that she and V7 found no pulse or active breathing for R1. V3 stated that she and V7 pronounced R1's death on 3/2/21 at 5:07 pm. V3 stated that she then notified V1 (Administrator), V2 (DON), V9 (Family Member), V10 (Family Member) and V13 (Medical Director) of R1's death.

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On 4/14/21 at 3:35 pm, when this surveyor asked V3 the code status of R1 on 3/2/21 at 5:07 pm, V3 stated, "O. M. G. (R1) was a full code." V3 stated that she rechecked R1's code status after he expired when she printed up R1's face sheet for V11 (Assistant Funeral Director) to sign for release of R1's body and then saw under advance directives that R1's code status was a full code. V3 stated that she then checked the code status binder at the nurse's station where DNR code status residents are listed and that R1 was "not in the binder." V3 stated that when a resident is a full code status and is found unresponsive, she will initiate CPR immediately, call 911 and to check the code status of the resident. V3 stated that she "must start CPR right away for a full code. It is vital. We have only minutes to restore circulation and prevent full brain damage." V3 stated that on 3/2/21, she did not initiate CPR for R1 and did not activate EMS by calling 911. V3 reiterated that she thought that R1 was a DNR code status.

R1's Minimum Data Set (MDS), dated 3/2/21, documents, in part, that R1's type of assessment for discharge reporting is "death in facility."

On 4/14/21 at 3:03 pm, V7 (LPN) stated that on 3/2/21, she was called to R1's room by V3 who informed her that V3 could not obtain any vital signs for R1 and that he was a DNR code status. V7 stated that since V3 said that R1 was a DNR code status, no further treatment was needed, and she left R1's room. V7 stated that a code blue was not called overhead in the facility for R1 on 3/2/21. V7 stated that no CPR was performed for R1 on 3/2/21.

On 4/15/21 at 8:32 am, V12 (Certified Nursing Assistant/CNA) stated that on 3/2/21 when R1

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returned from his outside appointment with V6 (CIT), V6 asked her for help in transferring R1 from his wheelchair to the bed. V12 stated that she went into R1's room along with V6 and that R1 was sitting in his wheelchair, "slumped over with his head leaning forward." V12 stated that V6 tried to shake R1, but R1 was unresponsive. V12 stated that she called for V3 (LPN) who was right outside the door to alert her about R1. V12 stated that V3 was shaking and talking to R1 for responsiveness and tried to feel for a pulse and "couldn't feel it." V12 stated that she, V3 and V7 transferred R1 from the wheelchair to his bed and placed him on his back. V12 stated that R1 was not responsive or moving during the manual transfer. V12 stated that V3 went outside R1's door and then V3 and V7 came back into R1's room. V12 stated that V3 used a stethoscope and stated that R1 had no pulse and "he's passed away." V12 stated that on 3/2/21, CPR was not performed on R1 and that no code blue was called for R1 in the facility.

In R1's progress note, dated 3/2/21 at 5:00 pm, V3 documented, "Upon medication rounds, (R1) observed in bed slumped over, unresponsive to tactile stimulation, No rise (and) fall of chest, no breathing, no pulse, no blood pressure (BP); two nurses pronounced expiration at 5:07 pm. (V13/Medical Director) informed. (V9, V10, Family Members) both aware; plan to send (funeral home services) as soon as possible. (V9, V10) will arrange to pick up belongings in am."

On 4/12/21 at 3:49 pm, V2 (DON) stated that on 3/2/21, she had already left the facility and received a phone call from V3 after 5:00 pm. In this phone call, V2 stated that V3 informed her that she found R1 with no rise or fall of his chest, couldn't obtain any vital signs and that R1 was a

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S9999	Continued From page 6 DNR code status. V2 stated that on 3/4/21, she received an allegation of R1 having an injury of unknown origin from V9 (Family Member). V2 stated that she timely reported the allegation to the state agency and started an investigation. V2 stated that after she performed a thorough investigation with multiple interviews and reviewing of R1's records, she concluded that R1 did not have any alleged bruising to his body when he left the facility on 3/2/21 after his passing. However, V2 stated that during R1's record review for the investigation, she saw that R1 had a physician's order for full code status, and R1 was listed as full code status on the profile face sheet in the electronic medical records (EMR). V2 stated that on 3/4/21, when she questioned V3 about R1's code status, V3 informed her that R1's code status was listed as a DNR on the face sheet that V11 (Assistant Funeral Director) signed for the release of R1's body to the funeral home. V2 stated that R1's face sheet that V11 signed documented full code status under advance directives. V2 stated that on 3/2/21, V3 did not perform CPR or any resuscitative measures for R1 who was a full code status. V2 stated that she took disciplinary action and that V3 did receive a three day suspension. In facility document, titled "Employee Disciplinary Action Form" and dated 3/18/21, V2 documented that V3 (LPN) received a suspension for the described incident: "(V3) failed to properly follow facility protocol for code blue. All employees must follow facility policy and procedures. Any further trends noted will lead to further disciplinary action not excluding termination. Employee will receive a 3 day suspension days March 12, 17, 18 of 2021." Both V2 and V3 signed this document on 3/12/21.	S9999		

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S9999	Continued From page 7 This surveyor reviewed R1's face sheet, which is titled as "Admission Record," that V11 (Assistant Funeral Director) signed on 3/2/21 at 9:15 pm for release of R1's body. This copy of R1's signed face sheet documents two smudged, nonvisible areas noted to be covered with a substance blocking the information under the advance directive section. Review of this copy of R1's face sheet signed by V11 contradicts both V2's and V3's previous statements of them viewing full code for R1's code status under the advance directive section of this signed face sheet. On 4/19/21 at 1:01 pm, this surveyor showed V2 the copy of R1's face sheet signed by V11 and asked V2 to explain what R1's code status was under the advance directive section of this signed face sheet. V2 stated, "I don't know what that is." This surveyor then requested to review R1's original copy of the face sheet that was signed by V11 for release of R1's body. On 4/19/21 at 1:33 pm, V2 presented this surveyor with the same copy of R1's signed face sheet by V11 for the release of R1's body that included the two smudged, nonvisible areas under the advance directive section. V2 stated that V3 would have put this copy in her mailbox after V11 signed it on 3/2/21, and V3 could have given V11 the original copy of R1's signed face sheet. V2 stated that normally the facility keeps the original version of the signed face sheet for release of the body and would give a copy of the original to the funeral home staff. R1's care plan, titled "Comprehensive Person-Centered Care Plan" and dated 2/11/21, documents, in part that R1's physical and psychosocial needs are met "in fulfillment of my	S9999		

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rights and my desire to retain control and autonomy over my health care decisions, I have executed a Full Code. Goals/Objectives: My wishes for Full Code status...will be honored and clearly delineated in the medical record in compliance with state law."

On 4/15/21 at 10:05 am, V2 (DON) stated that a facility nurse is required to look in the code status binder each shift for the resident's code status. V2 stated, "They should know the code status of the residents they are caring for." V2 stated that nurses can also locate a resident's code status in the EMR when they view the physician orders section. V2 stated, "No, you can't find the code status in the EMAR." V2 stated that CNA's can find the code status of a resident by asking the nurse or to look in the code status binder.

On 4/15/21 at 10:50 am, V13 (Medical Director) stated that he was R1's attending physician and that R1's main health problem was seizures. V13 stated that since he did not have access to R1's EMR during this interview, he could not recall R1's code status. V13 stated, "If you look in the (EMR), you will see it right there." This surveyor informed V13 that his order, dated 10/18/19, is in R1's EMR as a full code status resident. V13 stated that if a resident has a full code status and is found unresponsive, the expectation of the facility staff is "to start resuscitation, CPR, and call 911 to get help to the resident." V13 stated that staff caring for a resident in a long term care facility should know the code status of the residents. V13 stated that he does recall being notified by a nurse (V3) of R1's expiration on 3/2/21, but V13 did not recall the details of this notification. V13 then stated that "what happened with R1 should be documented" in the EMR. This surveyor then informed V13 that with interviews

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and record review, R1 was a full code status and expired in the facility on 3/2/21 without facility staff performing any life sustaining resuscitative measures or calling 911 when R1 was found unresponsive. When this surveyor asked V13 what effect this could have on R1, he stated, "Well, what actually occurred (to R1)." This surveyor asked V13 what occurred to R1 as meaning, "cause death," and V13 stated, "Yes."

Facility policy and procedure, titled "Medical Emergency (Code Blue)" and dated 6/2020, documents, in part: "Purpose: To provide care and services to residents in accordance with Advance Directives that have been discussed with the resident or resident's legal representative in advance of medical emergencies including medical interventions used to restore circulatory and respiratory function. Procedure: 1. The licensed nurse will be notified when any resident is determined to be non-responsive and a Code Blue will be called. 2. The resident ' s Code status will be identified within the resident ' s medical record... 5. Residents that do not have a signed DNR and DNR order will have CPR initiated and maintained. 6. If a resident is determined to be a Full Code (No DNR), 911 will be contacted at the initiation of CPR. CPR will continue until such time that EMS has arrived at the facility and assumes treatment of the resident."

The Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) Memo, S&C: 14-01-NH, with revised date of 1/23/15, documents, in part: " ...Initiation of CPR: Prior to the arrival of EMS, nursing homes must provide basic life support, including initiation of CPR, to a resident who experiences cardiac arrest (cessation of respirations and/or pulse) in accordance with that resident's advance

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S9999	Continued From page 10 directives or in the absence of advance directives or a DNR order." Facility policy and procedure, titled "Advanced Directive Life Sustaining Treatment and End of Life Care Policy and Procedure" and dated 11/26/2014, documents, in part: "It is the policy of this healthcare facility to assure residents and their families have the right to self-determination and the ability to make health care decisions and to appoint an agent to make decisions. It is the policy of this facility to provide residents information on advance directives including the Power of Attorney for Health Care and Living Will. The facility also educates residents and families about their rights concerning the right to refuse or accept medical or surgical treatment and to formulate advance directives including Do Not Resuscitate orders (DNR) and, in situations, in which the individual lacks decisional capacity and has not appointed a POAHC, the Surrogate Decision Maker for Health Care. Staff will review this material with the resident and family and provided needed education at the time of admission. Staff are responsible for following this policy/procedure and honoring the individual's advance directive choices. Definitions used in this policy: 1. Advance Care Planning - a process used to identify and update the resident's preferences regarding care and treatment at a future time including a situation in which the resident subsequently lacks the capacity to do so; for example, when a situation arises in which life sustaining treatments are a potential option for care and the resident is unable to make his or her choices known... 3. Cardiopulmonary Resuscitation (CPR) - refers to any medical intervention used to restore circulatory and/or respiratory function that has ceased... 8. Life Sustaining Treatment - treatment that, based on	S9999		

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reasonable medical judgment, sustains an individual's life and without which the individual will die. The term includes both life-sustaining medications and interventions such as mechanical ventilation, kidney dialysis, and artificial hydration and nutrition... 11. Treatment - refers to intervention provided for purposes of maintaining/ restoring health and well-being improving functional level, or relieving symptoms. Policy and Procedure: 1. Upon Admission: A. Designated staff will review Advance Directive options and the Statement on Illinois Law addressing Advance Directives and Life Sustaining Treatment with the resident and/or representative. Staff will provide the resident and/or representative with information regarding advance care planning which will address types of Advance Directives, treatment options and refusal of treatment. Information will be reviewed and the resident and/or representative will be asked to sign and acknowledge that they have received the information on Advance Care Planning. An Advance Directive form (as provided by the healthcare facility) will be completed with resident and/or legal representative to verify treatment options as well as code status (full code vs. DNR using the POLST {Practitioner Orders for Life Sustaining Treatment} document). Appropriate information will be added to Physician Order Sheet (POS). B. The resident ' s Advance Directive choices/options shall be reviewed periodically, for example, during the re-assessment process, as appropriate. According to CMS, the facility shall Identify, clarify, and periodically review, as part of the comprehensive care planning process, the existing care instructions and whether the resident wishes to change or continue these instructions. C. Discussion of Advance Directives and treatment options/refusals shall be

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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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addressed in appropriate chart documentation as well as care planned during the admission process. D. Staff shall initiate a resident choice discussion concerning the DNR option or Full Code. E. The facility shall document the individual's choices on the POLST and communicate the resident's choices to the interdisciplinary team through paper or virtual chart communication and/or team meetings, as appropriate... G. If the resident is unable or chooses not to initiate any type of Advance Directive the resident shall be viewed as a Full Code and shall receive appropriate life sustaining treatment interventions such as CPR... 4. Review of Advanced Directives: A. Advance Directive information should be reviewed periodically during the resident's stay. B. The staff shall review treatment options with the resident or legal representative to determine if the wishes remain the same or if changes are desired. This may occur in person, by telephone or email communication. C. The chart should be updated to record that advance directives were reviewed and the outcome of the conversation. It is expected that Social Service staff shall document this conversation."

Facility policy, titled "Physician Orders (Following Physician Orders)" (undated), documents, in part: "Policy: It is the policy of the facility to follow the orders of the physician. At the time of admission, the facility must have physician orders for the resident's immediate care. The facility will have orders to provide essential care to the resident, consistent with the resident ' s mental and physical status upon admission."

Facility document, titled "Job Description, Position Title: Licensed Practical Nurse" (undated), documents, in part: "Position Summary: The

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S9999	Continued From page 13 Licensed Practical Nurse provides direct nursing care to the residents, and supervises the day-to-day nursing activities performed by nursing assistants. The person holding this position has delegated the administrative authority, responsibility, and accountability for carrying out the assigned duties and responsibilities in accordance with current existing federal and state regulations and established company policies and procedures to ensure that the highest degree of quality care is maintained at all times. Essential Job Functions: A. Role Responsibilities - Administrative Duties: 1. Directs the day-to-day functions of the nursing assistants in accordance with current rules, regulations, and guidelines that govern the long-term care facility. 2. Ensures that all nursing personnel assigned to you comply with the written policies and procedures established by does facility. 3. Reviews the department's policies, procedure manuals...periodically... E. Role Responsibilities - Nursing Care: ...7. Reviews the resident's chart for specific treatments, medication orders, diets, etc. as necessary. 8. Implements and maintains established nursing objectives and standards... 21. Ensures that personnel providing direct care to residents are providing such care in accordance with the resident's care plan and wishes." Facility document, printed on 4/12/21 and titled, "Daily Census," documents that the total residents in the facility is 140. (AA) (Violation 2 of 2)	S9999		

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S9999	Continued From page 14 300.610a) 300.1010h) 300.1210b) 300.1210d)3) 300.1210d)6) 300.3240f) 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 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. Section 300.1210 General Requirements for Nursing and Personal Care	S9999		

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S9999	Continued From page 15 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. 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 f) Resident as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based 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	S9999		

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S9999	Continued From page 16 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 follow their policy to monitor and supervise a resident that exhibited destructive behavior. This deficient practice affected one resident (R5) in a sample of 4 residents (R2, R3, R4 and R5) reviewed for physical abuse. This failure led to R5 being physically assaulted by his roommate (R4) and sustaining facial trauma, feeling traumatized as a result of the incident, and not feeling safe in the facility requiring R5 being transferred to a local hospital for further evaluation and treatment of injuries sustained from the assault. Findings include: R4 is a 24-year-old man with diagnoses including but not limited to: Schizophrenia, Bipolar Disorder, and Cognitive Communication Deficit. R4's BIMS Score (Brief Interview for Mental Status) is 15 meaning the resident is Cognitively Intact. R5 is a 57-year-old man with the diagnoses including but not limited to: Difficulty in walking, Chronic Respiratory Failure, Pain in Right Hip, Abnormal Posture, Repeated Falls, Muscle Weakness, Muscle Wasting and Atrophy, Weakness, Reduced Mobility. R5's BIMS Score (Brief Interview for Mental Status) is 15 meaning the resident is Cognitively Intact. On 4/21/21 at 11:33 am R5 was observed in his	S9999		

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room. R5 was observed to be wheelchair bound. R5 stated on 4/10/21 he was in the hallway playing a game. When he returned to the room, R4 broke the televisions in their room (both R4's and R5's televisions). R5 stated R4 and he were roommates. R5 stated due to that incident, staff dismissed (put R4 in room next door) him to the room next door however R4 kept coming in back to the room (kept coming into room with R5). R5 stated on 4/13/21 he was in his wheelchair watching television with his back to the door. R4 came in, did not say anything and started swinging and hitting him. R5 stated R4 pulled him out of the wheelchair to the floor, got on top of him, put both of his knees on R5's arms so R5 could not protect himself and R4 was hitting his head and face. R5 stated all he could do was to yell for help while R4 was punching his face and head. R5 stated he was bleeding, had bruised lips and eyes. R5 stated, "Look at me. I am still bruised under my eye." R5 was observed with dark discoloration under his left eye. R5 stated he was traumatized at that time with the experience and he should not be abused in a nursing facility and that he should be feeling safe here.

On 4/21/21 at 11:09 am V4 (Social Service Director) stated on 4/12/21 in the morning V2 (Director of Nursing/DON) told her about the incident between R4 and R5. V4 stated R4 had a wander guard and was on the elopement list. V4 stated R4 was not placed on 1:1 supervision, there was no reason for that. V4 stated all staff will be making sure that the resident mood will be stable, and she was doing random checks and was making sure R4 was doing well and did wellness check. V4 stated regarding monitoring residents CNA's and nurses are always on the unit and they monitor residents, however she was not sure how often residents are to be monitored.

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S9999	Continued From page 18 On 4/21/21 at 12:01 pm, V22 (Nurse Practitioner) stated she was in the facility on 4/13/21 and was called to R5's room. V22 stated upon entry there was blood on the floor and R5 was picked up off the floor by staff. V22 stated both residents were separated by then. V22 stated she did an assessment on R5 because he was bleeding. V22 stated R5 had multiple trauma points; R5 had blood in nasal and oral cavity. V22 stated the trauma R5 sustained were all facial. R5's vital signs were stable. V22 stated she asked R5 how he obtained the trauma and R5 told her that R4 came into the room, pulled him out of the wheelchair and started to hit him. V22 stated R5 was sent out for hospital evaluation. On 4/21/21 at 1:09 pm V2 (DON) stated on 4/13/21 upon entering R4 and R5's room, she observed R5 on the floor, and there was blood on the floor also. V2 stated R4 was removed by staff already by the time she got to the room. V2 stated she was the nurse assigned to both residents that day. V2 stated R4 was never moved to a different room, his room number never changed. V2 stated on 4/10/21 R4 had a behavior where he broke the televisions in his room and staff took him to the common area, where he calmed down, and after he calmed down and did not exhibit any other behaviors he was able to come back to the room. V2 stated on 4/13/21 R4 and R5 were roommates and nothing was changed. On 4/21/21 at 1:37 pm V25 (Registered Nurse) stated she was familiar with R4 and he has not shown any behaviors in the past. V25 also stated R4's room has not changed prior to the 4/13/21 incident. V25 stated on 4/13/21 both residents had a word exchange and R4 physically assaulted R5. V25 stated when she got to the	S9999		

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room, V2 was in the room with R5. V25 stated R4 was removed from the room and she observed R4 was breathing heavy and was swaying back and forth. V25 stated R4 stated he wanted to be left alone, however he started to pace more, so she stayed on the unit with R4 because she wanted to make sure he was fine. V25 stated R4 was monitored, but he got more agitated and his behavior escalated so she called V27 (Psychiatrist) and informed the doctor that R4 was getting more aggressive and they got petition for him to go out for hospital evaluation. V25 also stated in the meantime R4 got Haldol because it was a 45-minute process, and he got transferred to the hospital due to escalation in behavior.

On 4/22/21 at 11:03 am V27 (Psychiatrist) stated on 4/13/21 she was made aware of R4's change in status related to behavior, incident between R4 and R5 and she gave an order for hospital evaluation and Haldol. V27 further stated she was not made aware on 4/10/21 of R4's behavior of being loud and disruptive (surveyor made V27 aware of R4's 4/10/21 progress note by V3/Licensed Practical Nurse). V27 stated she would have placed R4 on PRN (as needed) medication and close behavior monitoring due to change of condition. V27 stated she should have been made aware of the 4/10/21 incident by the facility and was not. V27 stated R4 is in his 20's living in a facility with an older population so any change in behavior she should be made aware. V27 stated when there is a change in condition related to behavior, she should be made aware and not a medical doctor or nurse practitioner.

On 4/22/21 at 11:10 am V2 (DON) stated when there is change in condition from baseline medical or behavior, then the nurse practitioner or physician needs to be made aware. V2 stated

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S9999	Continued From page 20 nurses need to call the doctor and let them know what is going on, follow orders if any and call the resident's family. V2 stated nurses are to document that they called the physician and document any orders given and in general what happened and who they spoke to in the resident's chart (progress notes). On 5/6/21 at 2:10 pm V2 stated she was aware of the 4/10/21 incident regarding R4 breaking the televisions in his room. V2 stated R4 was removed from the room to the room next door where he calmed down and relaxed and ate his meal. V2 stated the physician should have been notified because he had a behavior incident. V2 stated when it was discovered R4 broke the televisions, staff took him next door to find out what happened and that R4 was removed from the situation. V2 stated R4 was sorry he did it, calmed him down and there was no reason for room change because R4 was calm and remorseful. V2 stated when there is such an incident, staff need to deescalate the situation, separate the residents and find out why he broke the televisions. V2 stated R4 was redirected and was able to calm down, but yes doctor or nurse practitioner should have been made aware. R4's (4/10/2021 at 6:34 pm) Nursing Progress Note by V3 (Licensed Practical Nurse/LPN) documents: Resident loud and disruptive and destroyed 2 TV sets, behavior frightened neighbor (referring to R5); 2 nurses conquer resident move into room XXX, until further notice; Ambulatory, gait steady, appetite poor ate no dinner; Nurse talked to resident and stated he didn't mean to break the TV's, but is happy to move; Will continue to monitor. R4's (4/10/21) review of physician notes and	S9999		

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S9999	Continued From page 21 orders affirm physician was not notified and no orders to address resident's behavior were given. V3 was not available for interview. Surveyor attempted to reach her multiple times on 4/22/21 at 11:55 am, 11:57 am and 12:30 pm and 4/28/21 at 10:45 am, 10:47 am, 10:59 am, 3:10 pm and 3:25 pm. V1's (Administrator) (4/28/21) e-mail to surveyor documents V3 was out of the facility on suspension. R5's (4/13/2021) progress note by V22 (Nurse Practitioner) documents in part: Pt (Patient) seen and examined today for head/Facial trauma from another pt in the facility. Writer was called into pt's room, pt noted on the floor with blood on the floor next to pt's bed, pt transferred to his bed with aide of 2-3 staffs, upon assessment, pt noted with bloody discharge from his nasal and oral cavities, lacerations and swelling to pt's upper lip, and multiple swollen and trauma points. Upon asking pt how he sustained facial and head trauma, stated another pt in the facility approached him while he was sitting on his wheelchair watching a movie, dragged him down to the floor from which he hit his head to the floor and started punching him around his face and head, stated the other pt placed his knees on his hands restraining him, Trauma to facial and head region noted, Bil (bilateral) eye blood shot red, no other bodily harm noted, VSS (Vital Signs Stable) at this time, pt placed on high fowler's position and encouraged to let staff know of any change in condition. Pt alert and oriented x3-4, verbally responsive and able to answer all questions with no difficulty, stated he blacked out for a moment while he was being hit by the other pt, but regained consciousness right after.	S9999		

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S9999	Continued From page 22 Review of facility census affirms R4's was in the same room as R5 since 3/5/21, R4's room number did not change after 4/10/21 incident. R4 and R5 remained roommates. Facility's "Standard Supervision and Monitoring" policy documents in part: The facility recognizes supervision and guidance to the resident is an essential part of nursing care in which standard approaches are successful in meeting the resident's physical and psychosocial needs. 5. The physician/psychiatrist will be notified for further evaluation and treatment to further assess and treat the resident if increased supervision and guidance is required. (B)	S9999		