STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6013601	A. BUILDING: _____ B. WING _____	C 03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR HOUSE	760 OLD MCHENRY ROAD WHEELING, IL 60090

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S 000	Initial Comments Facility Reported Incident Investigation IL144275 from 2/4/22	S 000		
S9999	Final Observations Statement of Licensure Violations: 1 of 3 330.710a) 330.720b) Section 330.710 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 with the involvement of the administrator. The written policies shall be followed in operating the facility and shall be reviewed at least annually by the Administrator. Section 330.720 Admission and Discharge Policies b) No resident determined by professional evaluation to be in need of nursing care shall be admitted to or kept in a sheltered care facility. Neither shall any such resident be kept in a distinct part designated and classified for sheltered care. These requirements are not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to follow their admission and discharge policy by not assessing the need for skilled nursing services based on a decline in condition from being ambulatory by walking or	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1	S9999		

wheelchair to becoming bedridden, and total dependency on staff for care and services. This failure applies to two residents (R1 and R4) in a total sample of 4 residents reviewed for resident care needs.

Findings include:

R1 is a 90-year-old female originally admitted to the facility 10/10/2019.

R1's Admission progress note dated 10/10/2019 documents a diagnoses history of Dementia with Behavioral Disturbance, Alzheimer's, Major Depressive Disorder, Diastolic Congestive Heart Failure, Atherosclerotic Heart Disease of Native Coronary Artery, Chronic Bilateral Leg Edema, Breast Cancer with Mastectomy, Hyperlipidemia, Cerebral Infarction twice within the last 2 years, and Hip Fracture April 2019.

R1's admission physician assessment dated 10/11/2019 documents she has an unsteady gait, requires 2-person assistance when walking, and is mainly wheelchair bound.

R1's current service/care plan initiated 03/28/2021 documents she requires assistance with eating, grooming, dressing, peri care/toileting; and is incontinent of bowel and bladder.

R1's current physician orders do not include orders for hospice services.

On 03/02/2022 at 12:55PM Observed R1 in her room sitting in a geriatric recliner chair watching television.

R4 is a 58-year-old male with a diagnoses history

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S9999	Continued From page 2 of Dementia without Behavioral Disturbance, Alzheimer's Disease with Early Onset, and Mood Disorder who was originally admitted to the facility 9/17/2019. R4's admission physician assessment dated 09/27/2019 documents he walks independently. R4's current physician order sheet documents an active order effective 11/18/2020 for a mechanical lift for transfers associated with an extreme decline related to Covid-19 diagnosis; an active order effective 2/25/2022 for hospice care. R4's current service/care plan effective 02/03/2022 documents he requires total assistance with eating; requires assistance with all activities of daily living; and is incontinent of bowel and bladder. On 03/02/2022 at 1:00PM V6 (Certified Nursing Assistant) stated R4 is unable to move from his bed and totally dependent on staff. Observed R4 in his room lying in his bed. On 03/07/2022 from 9:55AM - 10:50AM V2 (Nurse Consultant) - stated we redefined for ourselves what sheltered care meant according to regulations and how we understood them. V2 stated under our review it is our expectation that people can remain in sheltered care through the end of life with the combined care of hospice. V2 stated the appropriateness for admission and discharge criteria is reviewed through end of life and it is our understanding that if the residents are receiving coordinated care through hospice, they would be still eligible for sheltered care. On 03/08/2022 at 9:26AM Observed R4 in his room lying in his bed attempting to speak but	S9999		

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S9999	Continued From page 3	S9999		

unable to communicate clearly. Observed a wedge pillow on R4's right side, a floor mat on the right side of his bed, and his bed in a lowered position. Observed R4's mattress to be a pressure relieving mattress. Observed no call light within R4's reach and no alarm device in use.

On 03/08/2022 at 9:35AM V5 (Certified Nursing Assistant) stated R4 is totally dependent on staff for care. V5 stated R4 is provided incontinence care every 2 hours. V5 stated R4 has been on hospice for approximately a month. Observed R4's room with a geriatric recliner chair. V5 stated R4 used to be able to walk and eat on his own but his health declined after having COVID-19.

On 03/08/2022 at 9:39AM V5 (Certified Nursing Assistant) stated R1 and R4 are totally dependent on staff for care and require 2 staff to provide incontinence care.

On 03/09/2022 from 1:32PM - 1:52PM V3 (Lead Nurse) stated R1 is not in hospice care. V3 state R1 has been bed bound since approximately 2 years ago. V3 stated R4 acquired COVID 19 in 2020. V3 stated some residents who developed COVID 19 experienced a decline in their health. V3 stated R4 was placed on hospice 02/25/2022. V3 stated R4 became bed bound 2 years ago.

On 3/09/2022 from 1:55PM - 2:29PM V2 (Nurse Consultant) stated skilled nursing care needs are based on assessments and considered on an individual basis. V2 stated a determination for skilled nursing care would have to be determined by the physician and nurse at the time of re-evaluating a resident. V2 stated R1 can be brought out into the common area with others and communicate her needs so she would not fit the

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S9999	Continued From page 4 criteria of bedridden. V2 stated R4 fits into the definition of bedridden based on not being able to communicate his needs, not being able to be out in the common area frequently and mostly confined to his room based on his condition. Discharge from Program Policy reviewed 03/08/2022 states: "Residents will be discharged from the Alzheimer Program for the following reasons. Non-Urgent Discharge: Inappropriate placement in Alzheimer's Care Program due to but not limited to: Need for skilled care (G-Tube, IV's, etc.) Becoming bed-ridden unless on hospice. The resident is adversely affected by the Alzheimer Program environment." Admission Packet reviewed 03/08/2022 states: "You agree that (the facility) may from time to time assess your health to determine the appropriate Personal Service Plan and/or whether you are appropriate to stay in the residence. Not more than thirty (30) days prior to the date this Agreement is entered, and at least annually thereafter or upon the request of (the facility), you agree to undergo an examination by your physician (or other licensed provider as allowed by law). You will request the examiner to provide (the facility) with recommendations, including a statement attesting to the appropriateness of the placement." "(The facility) may terminate this Agreement, upon providing you or your Responsible Party thirty (30) days written notice, for any of the following events, as determined by (the facility): You require care other than that which the residence is licensed to provide.	S9999		

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S9999	Continued From page 5 (A) 2 of 3 330.710a) 330.710c)3)A) 330.910b) Section 330.710 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 with the involvement of the administrator. The written policies shall be followed in operating the facility and shall be reviewed at least annually by the Administrator. The policies shall comply with the Act and this Part. c) The written policies shall include, but are not limited to, the following provisions: 3) A policy to identify, assess, and develop strategies to control risk of injury to residents and nurses and other health care workers associated with the lifting, transferring, repositioning, or movement of a resident. The policy shall establish a process that, at a minimum, includes all of the following: A) Analysis of the risk of injury to residents and nurses and other health care workers, taking into account the resident handling needs of the resident populations served by the facility and the physical environment in which the resident handling and movement occurs. Section 330.910 Personnel	S9999		

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S9999	Continued From page 6 b) Sufficient staff in numbers and qualifications shall be on duty all hours of each day to provide services that meet the total needs of the residents. As a minimum, there shall be at least one staff member awake, dressed, and on duty at all times. These requirements are not met as evidenced by: A) Based on interviews and record reviews the facility failed to follow their fall policy by not reassessing residents who are at risk for falls in a timely manner for the identification of necessary interventions to prevent accidents resulting in multiple resident injuries. This failure applies to a total sample of two residents (R2 and R4) reviewed for falls. B) Based on interviews and record reviews the facility failed to follow their staffing policies and procedures by not ensuring sufficient levels of staff are available to provide necessary care and services for residents who require a higher level of care and supervision. This failure applies to two residents (R1 and R2) in a total sample of 4 resident's reviewed for staffing. Findings include: A) R2 is a 63-year-old male with a diagnosis's history of Alzheimer's Disease, Major Depressive Disorder, and Mood Disorder who was originally admitted to the facility 4/28/2021. On 03/02/2022 at 1:07PM Observed R2 nodding off at times while standing up. V6 (Certified Nursing Assistant) stated R2 doesn't sleep well at night which is why he has this behavior during the day. V5 (Certified Nursing Assistant) and V6	S9999		

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S9999	Continued From page 7	S9999		

stated R2 is always walking around and nodding but won't sit down and rest. Observed R2 was unable to communicate.

R2's Progress note dated 01/01/2022 (Licensed Practical Nurse) documents: Staff heard a loud noise coming from R2's room; they immediately ran to his room and found R2 in the floor. Writer assessed patient and noted a laceration of 2.5cm on the back of his head, active bleeding. Will continue to monitor.

R2's Progress note dated 01/27/2022 documents: certified nursing assistant reported R2 had an unwitnessed fall this morning at 10am found R2 ambulated in hallway with minimal bleeding from his head. R2 noted with a laceration approximately 4.5cm length. One to one care given and closely supervised.

R2's incident report dated 01/27/2022 documents he experienced an unwitnessed fall and was observed ambulating bleeding from his head.

R2's incident investigation report dated 01/28/2022 documents: R2 was observed at approximately 10AM walking in the halls with blood on his head and a laceration injury on the top of his head; on 01/28/2022 R2 was observed by Certified Nursing Assistant's traveling the hall near R1's room with blood running down his head; staff were unable to confirm where he might have fallen; R2 has poor safety awareness and unsteady gait; it was determined his injury was likely the result of him tripping and falling then and he continued ambulating after the fall.

R2's most recent fall risk assessment was conducted 04/28/2021 and documents he is at high risk for falls.

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S9999	Continued From page 8 R4 is a 58-year-old male with a diagnosis's history of Dementia without Behavioral Disturbance, Alzheimer's Disease with Early Onset, and Mood Disorder who was originally admitted to the facility 9/17/2019. R4's previous fall risk assessment was conducted 08/20/2021 and documents he is at moderate risk for falls. R4's next quarterly fall risk assessment was conducted 03/07/2022 and documents he is at moderate risk for falls. Incident/Fall log from September 2021 - February 2022 reviewed 03/03/2022 documents: R1's bumped eyebrow on wall 09/14/2021; documents R2 had a fall resulting in a skin tear 01/01/2022, and had a fall with head injury 01/27/2022, and does not include R2's scratch to right side of mouth and a small opening on right side of mouth along with bleeding on 12/29/2021. On 03/07/2022 from 9:55AM - 10:50AM V2 (Nurse Consultant) stated typically fall risk assessments are conducted as part of a change of condition assessment based on changes in their physical or mental condition or medication regimen. V2 stated residents should be assessed for falls on admission, quarterly, annually, and upon a change in condition based on the facility's policy. Fall policy reviewed 03/03/2022 states: "Purpose: To consistently identify and evaluate residents at risk for falls and those who have fallen to treat or refer for treatment appropriately and develop and organization-wide ownership for fall prevention to: To achieve each resident's maximum	S9999		

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S9999	Continued From page 9	S9999		

potential of physical functioning.
To prevent or reduce injuries related to falls.
To enhance resident dignity and self-worth.
To rehabilitate residents to their fullest potential of function."
"The intent of this guideline is to ensure this facility provides and environment that is free from hazards over which the facility has control and provides appropriate supervision to each resident as identified through the following process:
Identification of hazards and risks
Evaluation
Implementation
Monitoring
Analysis"
"A fall evaluation is used to identify individuals who have predicting factors for falls. This evaluation is completed upon admission, quarterly, annually, and with a significant change in condition."

B) R1 is a 90-year-old female with a diagnosis's history of Dementia with Behavioral Disturbance, Alzheimer's, Major Depressive Disorder, Diastolic Congestive Heart Failure, Atherosclerotic Heart Disease of Native Coronary Artery, and Cerebral Infarction who was originally admitted to the facility 10/10/2019.

R1's incident report form dated 09/14/2021 documents at 10PM while V5 (Certified Nursing Assistant) was providing peri care to R1 she turned R1 to her right side and bumped her right eyebrow on the wall; first aid was provided as well as a nurse assessment; the incident was witnessed by V5; no other witnesses were listed; injury included her right eyebrow

Progress note dated 09/15/2021 documents a

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S9999	Continued From page 10 certified nursing aid reported to writer while providing care and turning R1 last night, R1 had an abrasion to right eyebrow 3cm in length. R2 is a 63-year-old male with a diagnosis's history of Alzheimer's Disease, Major Depressive Disorder, and Mood Disorder who was originally admitted to the facility 4/28/2021. On 03/02/2022 at 1:07PM Observed R2 nodding off at times while standing up. V6 (Certified Nursing Assistant) stated R2 doesn't sleep well at night which is why he has this behavior during the day. V5 (Certified Nursing Assistant) and V6 stated R2 is always walking around and nodding but won't sit down and rest. Observed R2 was unable to communicate. R2's Progress note dated 01/27/2022 documents: certified nursing assistant reported R2 had an unwitnessed fall this morning at 10am found patient ambulated in hallway with minimal bleeding from his head. Writer assessed R2 immediately head to toe, R2 noted with a laceration approximately 4.5cm length. One to one care given and closely supervised. Hospice and facility team will continue to monitor laceration of patient's head until resolved. R2's incident report dated 01/27/2022 documents he experienced an unwitnessed fall and was observed ambulated bleeding from his head. on 01/28/2022 R2 was observed by to Certified Nursing Assistant's traveling the hall near a room (R1's room) with blood running down his head; staff were unable to confirm where he might have fallen; R2 has poor safety awareness and unsteady gait; it was determined his injury was likely the result of him tripping and falling then and he continued ambulating after the fall; V5	S9999		

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S9999	Continued From page 11 (Certified Nursing Assistant) was interviewed 01/31/2022 and stated at approximately 10AM while she and V7 (Certified Nursing Assistant) were providing incontinence care to a resident in their room, they left the room and saw R2 walking in the hallway with blood on his head and immediately notified the nurse. On 03/02/2022 at 1:07PM V5 (Certified Nursing Assistant) stated on 01/27/2022 she and V7 (Certified Nursing Assistant) were in a resident's room providing incontinence care, heard a loud thump coming from outside the room then observed R2 in the hall bleeding. V5 reported there were only 2 CNA's working in the house when this incident occurred. V5 and V6 (Certified Nursing Assistant) stated there are usually 2 CNA's working in the housing unit. V6 stated at times there is only one CNA (Certified Nursing Assistant) working in the housing unit. V5 stated at least 3 CNAs are needed for the housing unit where R1 and R2 are located due to requiring 2 staff at a time to provide care for some of the residents. V5 and V6 stated a floater comes to assist only when they are short staffed. V6 stated there were only 2 CNA's working 12/27/2021 when R2 became injured. On 03/02/2022 at 1:20PM V6 (Certified Nursing Assistant) stated if she and the other certified nursing assistant assigned to the housing unit where R1 and R2 are located need to provide incontinence care or care that requires 2 staff, they will request a nurse or activities staff to monitor the other residents. V5 (Certified Nursing Assistant) and V6 stated all the residents in R1 and R2's housing unit need to be monitored at all times. On 03/02/2022 at 1:26PM V5 (Certified Nursing	S9999		

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S9999	Continued From page 12 Assistant) stated the day R2 fell on 01/27/2022, there were only 2 CNA's working in the housing unit and no one was available to come and monitor the other residents while she and V7 (Certified Nursing Assistant) were providing incontinence care. V5 stated because there was no staff available to provide assistance, she and V7 did not request assistance from staff to monitor the other residents while they were providing incontinence care during the time R2 fell. On 03/07/2022 from 9:55AM - 10:50AM V2 (Nurse Consultant) stated the facility follows staffing requirements set forth in policy and procedure. V2 stated sometimes the facility is overstaffed and sometimes understaffed. V2 stated staffing is assigned based on level of assistance needed for residents and the staffing ratio can be elevated to 3 people if necessary. V2 stated the facility also uses support staff such as nurses and activities staff. V2 stated all facility staff can be utilized for assistance. V2 stated depending on the level of care needed for residents the facility can alter staffing requirements. V2 stated at all times there should be no less than 2 staff members per house and can increase as needed. V2 stated the house where R1, R2, and R3 are located typically requires the highest level of assistance. V2 stated on any given day if needed resident care specialist, activities staff, floaters, management etc. can all provide assistance. V2 stated for whatever reason there was some poor judgment involved in R2's accident on 01/27/2022. V2 stated judgment should be made to determine when more monitoring is necessary. V2 stated if residents are in the common area together and we're aware that they have a certain propensity for falling we know they need to be monitored.	S9999		

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S9999	Continued From page 13 On 03/08/2022 at 9:39AM V5 (Certified Nursing Assistant) stated R1, R4, and R5 are totally dependent on staff for care, and all require 2 staff to provide incontinence care. V5 stated R1, R4, and R5 are combative when providing incontinence care. V5 stated at times R2 requires 2 staff to toilet him depending on his mood. V5 stated it is not feasible to conduct room check rounds every 15 minutes due to the amount of monitoring needed for the resident population in this housing unit. V5 stated the resident population in the house where R1, R2, R3, and R5 are located require a lot of attention and it would be better to have at least 3 staff working in this house. On 03/08/2022 at 9:50AM V8 (Activities Assistant) stated she has worked for the facility since December 2021. V8 stated she makes her own schedule and visits all 3 housing units when working. V8 stated she spends a few hours at a time in each housing unit. V8 stated she has occasionally been requested for assistance to distract residents when staffing is short or on a very busy day but is usually able to conduct her activities schedule without being pulled away to assist. On 3/09/2022 from 1:55PM - 2:29PM V2 (Nurse Consultant) stated the house where R1, R2, R3, and R5 are located has always been the house where residents have a higher level of needs and requires higher staffing ratios. Staffing schedules from September 2021 to March 2022 reviewed. Staffing schedule dated 09/14/2022 documents one certified nursing assistant was assigned to the house where R1 is located for 3-11PM shift;	S9999		

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	IL6013601	A. BUILDING: _____ B. WING _____	C 03/09/2022

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S9999	Continued From page 14 one floater V11 (Certified Nursing Assistant) was scheduled for the 3-11PM shift; and one 3-11PM shift was uncovered; Staffing schedule dated 12/26/2021 documents there was 1 certified nursing assistant assigned from 11PM - 7AM and one uncovered shift for the house where R3 is located; Staffing schedule dated 12/27/2021 documents there were 2 certified nursing assistants assigned from 7AM - 3PM to the house where R3 is located. Staffing schedule dated 01/27/2022 documents there were there were 2 certified nursing assistants assigned from 7AM - 3PM to the house where R2 is located. Staffing Budget sheet reviewed 03/08/2022 documents 2 CNA's (Certified Nursing Assistants) are assigned across all shifts to the house where R1, R2, R3, and R5 are located, and one nurse is assigned per shift to all 3 of the facility's houses with a PRN (As needed Nurse) assigned depending on the facility's staffing needs. (B) 3 of 3 330.710a) 330.1150h) Section 330.710 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 with the involvement of the administrator. The written policies shall be followed in operating the facility and shall be reviewed at least annually by the Administrator. The policies shall comply with the Act and this Part.	S9999		

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S9999	Continued From page 15 Section 330.1150 Emergency Use of Physical Restraints h) No form of seclusion shall be permitted. These requirements are not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to follow their abuse policy by not avoiding professional practices that could potentially lead to physical or emotional harm. This failure applies to two residents (R1 and R4) in a total sample of 4 residents reviewed for abuse. Findings include: R1 is a 90-year-old female with a diagnoses history of Dementia with Behavioral Disturbance, Alzheimer's, Major Depressive Disorder, Diastolic Congestive Heart Failure, Atherosclerotic Heart Disease of Native Coronary Artery, and Cerebral Infarction who was originally admitted to the facility 10/10/2019. On 03/02/2022 at 12:48PM Observed R1's room door was locked. On 03/02/2022 at 12:50PM V5 (Certified Nursing Assistant) stated R1 is in her room with the door locked. V5 stated the residents room doors are locked because there are some residents who roam into other resident's rooms. On 03/02/2022 at 12:55PM Observed R1 in her room sitting in a geriatric recliner chair positioned near the center of her room with no call light accessible. Observed no alarm devices in use for R1.	S9999		

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S9999	Continued From page 16 On 03/08/2022 at 9:39AM V5 (Certified Nursing Assistant) stated she is not sure how R1 would access her call light and R1 is totally dependent on staff for care. R4 is a 58-year-old male with a diagnoses history of Dementia without Behavioral Disturbance, Alzheimer's Disease with Early Onset, and Mood Disorder who was originally admitted to the facility 9/17/2019. On 03/02/2022 at 12:56PM Observed R4's room door locked while in his room. On 03/02/2022 at 1:00PM V6 (Certified Nursing Assistant) stated R4 is unable to move from his bed and totally dependent on staff. On 03/07/2022 from 9:55AM - 10:50AM V2 (Nurse Consultant) stated she doesn't know if locking resident's doors is considered a facility policy but rather an intervention used by the facility. V2 stated resident's do wander and shop in resident's rooms and some residents and their families become very unhappy when their items are gone through. V2 stated if a resident is in their room with the door locked staff check on them frequently. V2 stated the facility does try to keep people from intruding on resident's spaces. V2 stated sometimes locking the resident's room doors is done to prevent losing a wandering resident. V2 stated there are a lot of potential concerns that could occur if a resident is in their room with the door locked which is why staff should be checking on them frequently. V2 stated when residents are in their rooms with the doors lock staff should be conducting 15-minute checks. V2 stated it would not be a best practice to just lock someone in their room and not check on them. V2 stated potential concerns with	S9999		

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S9999	Continued From page 17 residents being in their rooms with their doors locked include someone falling and not be seen for a long time. V2 stated she would have to look at each resident's situation specifically to determine other potential concerns. On 03/08/2022 at 9:35AM V5 (Certified Nursing Assistant) stated she conducts rounds to check on residents in the house where R1 and R4 are located every 30 minutes and used to keep a log for resident checks, but the facility no longer uses these logs. On 03/08/2022 at 10:30AM V1 (Executive Director) stated Administrative Coad Section 330.3110 Bedrooms, allows the resident's room doors to be keyed on the corridor side to prevent others from entering which applies to the facility's practice of locking resident's room doors. On 03/09/2022 from 1:55PM - 2:29PM V2 (Nurse Consultant) stated R1 becomes irritated just like a lot of residents do when other residents wander in her room. V2 stated there's always a safety issue whenever a resident is alone in their room particularly during the night. V2 stated the responsibility is on the staff to review the safety of the residents. V2 stated there is a risk anytime a resident is alone in their room and doesn't have the mental capacity to operate in that room by themselves. V2 stated because of the R1's condition she doesn't have the ability to open her room door even if it is closed and not locked. Policy on Locking Residents Room Doors reviewed 03/08/2022 states: "For residents requiring maximum assistance, residents will remain in the common areas as much as possible. If residents who require this level of care should be in their room, whether	S9999		

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S9999	Continued From page 18 locked or not, staff will round on resident's every 30 minutes, including Caregivers, CNA' (Certified Nursing Assistants), Nurses, and Activity Aides. The facility's abuse policy reviewed 03/03/2022 states: "Any action where proper policy or professional practices was intentionally disregarded and the associate could reasonably foresee the probable physical or emotional harm that his or her actions could cause the resident, is also considered abuse, neglect, or misconduct." Administrative Code Section 330.330 states: Seclusion includes the retention of a resident alone in a room with a door that the resident cannot open. (C)	S9999		