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	IL6005029	A. BUILDING: ______ B. WING ______	02/14/2024

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ROYAL OAKS CARE CENTER	605 EAST CHURCH STREET KEWANEE, IL 61443

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S 000	Initial Comments Complaint Investigations: 23210771/IL168207 2420803/IL169268 Investigation of Facility Reported Incident of January 23, 2024/IL169181	S 000		
S9999	Final Observations Statement of Licensure Violations I of II: 300.610a) 300.1210b)4)5) 300.1210d)6) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care 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	S9999		

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resident to meet the total nursing and personal care needs of the resident.

4) All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene.

5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning.

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:

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.

Based on observation, interview, and record review the facility failed to adequately supervise a resident while showering. The facility also failed to transfer a resident with assistance of two staff as directed by the plan of care to prevent a fall for one of three residents (R55) reviewed for falls in the sample of 76. These failures resulted in R55 sustaining a fall while in the shower room, resulting in R55 suffering a head injury, head

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swelling, left ankle swelling with bruising, neck pain, and a traumatic hematoma to the forehead which required hospital treatment.

Findings include:

R55's Admission Record documents R55 was admitted on 5-5-17. This same form documents R55 has the following, but not limited to, diagnoses: Mild Intellectual Disabilities, Chronic Obstructive Pulmonary Disease, Morbid (Severe) Obesity due to excess calories, Anxiety Disorder, Hemiplegia and Hemiparesis following Nontraumatic Subarachnoid Hemorrhage affecting left non-Dominant side, Weakness, Polyneuropathy, and Difficulty in Walking.

R55's Care Plan dated 1-17-24 documents on 9-22-23 documents R55 is a high risk for falls and has right-side hemiplegia, bilateral weakness, and impaired cognition and safety awareness. This same care plan documents on 9-22-23 an intervention to assist to transfer R55 using a mechanical device and/or two staff members.

R55's AIM (Acute Illness Management) for Wellness Event Record dated 11-23-23 at 7:05 AM documents V3 (CNA/Certified Nursing Assistant) was assisting R55 with transferring from the shower chair to the stand bar in the shower room. R55 became weak and lost her balance. V3 (CNA) lowered R55 to the floor. R55 then complained of pain and had bruising to the left knee. R55 was sent to the local ED (Emergency Department) for evaluation.

R55's Emergency Department Notes dated 11-11-23 documents, "Chief Complaint: (R55) presents with fall, head injury (left anterior), head swelling, and neck pain." This same form

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S9999	Continued From page 3 documents R55 suffered from a fall at nursing home and has a traumatic hematoma to the forehead. R55's CT (Computed Tomography) Head Scan dated 11-11-23 documents, "Impression: Acute posttraumatic left frontal scalp hematoma." R55's Left Ankle X-Ray dated 11-11-23 documents, "Soft tissue swelling." R55's Progress Notes dated 11-12-23 at 1:45 PM documents, "(R55) left ankle has a purple discoloration to it, moderate swelling, and is having some discomfort to it. X-Ray results sent to advanced practice nurse and new order to ice, elevate, and PRN (As Needed) APAP (Acetaminophen)." On 1-29-24 at 9:55 AM V3 (CNA) stated, "On 11-11-23 I heard (R55) yelling for help so I went into the shower room. (R55) had tried to stand up by herself from the shower chair to grab bars on the wall. (R55) got weak and I had to lower her to the floor. I was the only one transferring (R55). I did not know (R55) needed two staff for transfers or could not be left unattended in the shower." On 1-29-24 V5 (CNA) and V8 (CNA) both stated that R55 should always be a two assist for transfers and sometimes they even have to use a (mechanical) lift to transfer R55. V5 and V8 verified R55 should never be transferred with just one assist and should not be left alone in the shower room. On 1-30-24 at 10:00 AM (R55) was crying with visible tears and stated, "I was left alone in the shower room for a long time. I had to yell for help. There was a bunch of water on the floor.	S9999		

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Someone came in and tried to get up me up and I slid and fell. I hit my head and knee. I hurt my back and neck."

On 1-30-24 at 10:30 AM V9 (LPN/Licensed Practical Nurse) stated, "(R55) can stand during transfers, but requires two assists. (R55) becomes unsteady periodically, so requires a (mechanical) lift at times."

On 1-30-24 at 1:00 PM (AIT/Administrator in Training) stated that he was a therapist in the past and after reviewing R55's care plan confirmed that R55 should have been a two assist when being transferred in the shower room on 11-11-23.

The facility's Fall Prevention policy dated 11-10-18 documents, "Policy: To provide for resident safety and to minimize injuries related to falls; decrease falls and still honor each resident's wishes/desires for maximum independence with mobility. Responsibility: All staff. Procedure: 1. Conduct fall assessments on the day of admission, quarterly, and with a change in condition. 2. Identify, on admission, the resident's risk for falls. 4. Assignment of the final risk category will be determined by the Interdisciplinary Team (IDT) at their conferences based on: a. Fall risk score. b. History of falls. c. Medical condition which directly impacts on equilibrium and/or ambulation. d. Discussion of individual circumstances. 7. Report all falls during the morning Quality Assurance meetings Monday through Friday. All falls will be discussed in the Morning Quality Assurance meeting and any new interventions will be written on the care plan."

"B"

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Statement of Licensure Violations II of II:
300.510c)
300.610a)
300.615e)
300.625c)2)
300.625i)
300.625j)
300.650e)
300.650f)1)2)3)
300.1210a)
300.1210b)
300.1210d)3)6)
300.1810k)
300.3210t)
300.3300j)
300.3300l)
300.3300n)
300.3300o)

Section 300.510 Administrator
c) The administrator shall arrange for facility supervisory personnel to annually attend appropriate educational programs on supervision, nutrition, and other pertinent subjects.

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.

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Section 300.615 Determination of Need Screening and Request for Resident Criminal History Record Information
e) In addition to the screening required by Section 2-201.5(a) of the Act and this Section, a facility shall, within 24 hours after admission of a resident, request a criminal history background check pursuant to the Uniform Conviction Information Act for all persons 18 or older seeking admission to the facility, unless a background check was initiated by a hospital pursuant to the Hospital Licensing Act. Background checks shall be based on the resident's name, date of birth, and other identifiers as required by the Department of State Police. (Section 2-201.5(b) of the Act)

Section 300.625 Identified Offenders
c) If the results of a resident's criminal history background check reveal that the resident is an identified offender as defined in Section 1-114.01 of the Act, the facility shall do the following:
2) Within 72 hours, arrange for a fingerprint-based criminal history record inquiry to be requested on the identified offender resident. The inquiry shall be based on the subject's name, sex, race, date of birth, fingerprint images, and other identifiers required by the Department of State Police. The inquiry shall be processed through the files of the Department of State Police and the Federal Bureau of Investigation to locate any criminal history record information that may exist regarding the subject. The Federal Bureau of Investigation shall furnish to the Department of State Police, pursuant to an inquiry under this subsection (c)(2), any criminal history record information contained in its files.

i) For current residents who are identified offenders, the facility shall review the security

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measures listed in the Identified Offender Report and Recommendation provided by the Department of the State Police.

j) Upon admission of an identified offender to a facility or a decision to retain an identified offender in a facility, the facility, in consultation with the medical director and law enforcement, shall specifically address the resident's needs in an individualized plan of care.

Section 300.650 Personnel Policies
e) All personnel shall have either training or experience, or both, in the job assigned to them.

f) Orientation and In-Service Training
1) All new employees, including student interns, shall complete an orientation program covering, at a minimum, the following: general facility and resident orientation; job orientation, emphasizing allowable duties of the new employee; resident safety, including fire and disaster, emergency care and basic resident safety; infection prevention and control; and understanding and communicating with the type of residents being cared for in the facility. In addition, all new direct care staff, including student interns, shall complete an orientation program covering the facility's policies and procedures for resident care services before being assigned to provide direct care to residents.

2) All employees, except student interns shall attend in-service training programs pertaining to their assigned duties at least annually. These in-service training programs shall include the facility's policies, including infection prevention and control policies required in Section 300.696, skill training and ongoing education to enable all personnel to perform their duties effectively. The

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in-service training sessions regarding personal care, nursing and restorative services shall include information on the prevention and treatment of decubitus ulcers. In-service training concerning dietary services shall include information on the effects of diet in treatment of various diseases or medical conditions and the importance of laboratory test results in determining therapeutic diets. Written records of program content for each session and of personnel attending each session shall be kept.

3) All facilities shall provide training and education on the requirements of Section 2-106.1 of the Act and Section 300.686 of this Part to all personnel involved in providing care to residents, and train and educate those personnel on the methods and procedures to effectively implement the facility's policies. Training and education provided under Section 2-106.1 of the Act and Section 300.686 shall be documented in each personnel file. (Section 2-106.1(b-15) of the Act)

Section 300.1210 General Requirements for Nursing and Personal Care

a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the

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resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)

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 300.1810 Resident Record Requirements
k) Discharge information shall be completed within 48 hours after the resident leaves the facility. The resident care staff shall record the date, time, condition of the resident, to whom released, and the resident's planned destination (home, another facility, undertaker). This information may be entered onto the admission record form.

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Section 300.3210 General
t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property.

Section 300.3300 Transfer or Discharge
j) The planned involuntary transfer or discharge shall be discussed with the resident, the resident's representative and person or agency responsible for the resident's placement, maintenance, and care in the facility. The explanation and discussion of the reasons for involuntary transfer or discharge shall include the facility administrator or other appropriate facility representative as the administrator's designee. The content of the discussion and explanation shall be summarized in writing and shall include the names of the individuals involved in the discussions and made a part of the resident's clinical record. (Section 3-408 of the Act)

l) A resident subject to involuntary transfer or discharge from a facility, the resident's guardian or if the resident is a minor, his or her parent shall have the opportunity to file a request for a hearing with the Department within 10 days following receipt of the written notice of the involuntary transfer or discharge by the facility. (Section 3-410 of the Act)

n) The hearing before the Department provided under subsection (m) of this Section shall be conducted as prescribed under Section 3-703 of the Act. In determining whether a transfer or discharge is authorized, the burden of proof in this hearing rests on the person requesting the transfer or discharge. (Section 3-412 of the Act)

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o) If the Department determines that a transfer or discharge is authorized under subsection (c) of this Section, the resident shall not be required to leave the facility before the 34th day following receipt of the notice required under subsection (d) of this Section, or the 10th day following receipt of the Department's decision, whichever is later, unless a condition which would have allowed transfer or discharge in less than 21 days as described under subsections (d)(1) and (2) of this Section develops in the interim. (Section 3-413 of the Act)

This REQUIREMENT is not met as evidenced by:

A. Based on interview and record review the facility failed to ensure a background check was completed within 24 hours of admission for 20 of 47 residents (R2, R4, R7, R8, R13, R17, R21, R25, R26, R32, R42, R56, R64, R66, R68, R69, R70, R71, R73, and R76) reviewed for background checks in a sample of 76.

Findings Include:

The facility's Identified Offender Policy and Procedure documents, "Policy Statement: It is the policy of this facility to establish a resident sensitive and resident secure environment. In accordance with the provisions of the Nursing Home Care Act, this facility shall check the criminal history background on any resident seeking admission to the facility in order to identify previous criminal convictions. It is the policy of (the facility) that no person will be admitted if they are sex offenders. Responsibility: Administrator or a person designated by the Administrator. Identifying Offenders: 3. Conduct a Criminal History Background Check: Within 24

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hours of admission, request a name-based Uniform conviction Information ACT (UCIA) criminal history background check based on name, date of birth, and other identifiers required by the Department of State Police for any resident seeking admission to the facility."

R2, R4, R7, R8, R13, R17, R21, R25, R26, R32, R42, R56, R64, R66, R68, R69, R70, R71, R73, and R76's Business Office File and Medical Records do not contain evidence of the facility obtaining background checks of these residents since admission to the facility.

On 2-7-24 at 10:15 AM V54 (Business Office Manager) verified R2, R4, R7, R8, R13, R17, R21, R25, R26, R32, R42, R56, R64, R66, R68, R69, R70, R71, R73, and R76 did not have a background check done within 24 hours of their admission.

B. Based on interview and record review, the facility failed to obtain fingerprints for residents who are Identified Offenders within 72 hours of admission. This affected nine residents (R3, R11, R27, R34, R36, R54, R57, R59, and R75) of 47 Residents in a sample of 76.

Findings include:

The facility's Identified Offender Policy and Procedure documents, "Policy Statement: It is the policy of this facility to establish a resident sensitive and resident secure environment. In accordance with the provisions of the Nursing Home Care Act, this facility shall check the criminal history background on any resident seeking admission to the facility in order to identify previous criminal convictions. It is the

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policy of (the facility) that no person will be admitted if they are sex offenders. Responsibility: Administrator or a person designated by the Administrator. Identifying Offenders: 3. Conduct a Criminal History Background Check: Within 24 hours of admission, request a name-based Uniform conviction Information ACT (UCIA) criminal history background check based on name, date of birth, and other identifiers required by the Department of State Police for any resident seeking admission to the facility. Reporting Results If the Resident is an Identified Offender: 1. Once the facility determines the resident is an Identified Offender, the facility must request in 72 hours for the resident to undergo a live scan State and Federal Bureau of Investigation (FBI) fingerprint check within five business days."

The Nursing Home Resident Fingerprint Consent Form (Fee Applicant Transaction), states, "Nursing homes are required to arrange for the fingerprinting of residents they determine to be Identified Offenders. This form must be signed by the applicant to authorize the release of any criminal history record information that may exist regarding the applicant. Once the form is completed and signed, the original copy is to be retained in the files of the nursing home facility. Once copy is to be provided to the live scan fingerprinting vendor and one copy is to be given to the applicant. The applicant is required to undergo an Illinois State Police and Federal Bureau of Investigation (national) fingerprint based criminal history record information inquiry if the nursing home was deemed the applicant to be an identified offender."

R3, R11, R27, R34, R36, R54, R57, R59, and R75 UCIA (Uniform Conviction Information Act) background checks document R3, R11, R27,

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R34, R36, R54, R57, R59, and R75 had a documented hit that would require criminal fingerprinting to be conducted to determine of a resident is high, moderate, or low risk offender. No fingerprinting has yet to be conducted for R3, R11, R27, R34, R36, R54, R57, R59, and R75.

On 2-7-24 at 10:00 AM V54 (Business Office Manager) verified R3, R11, R27, R34, R36, R54, R57, R59, and R75 UCIA (Uniform Conviction Information Act) background checks had qualifying identified offender convictions and these residents did not receive fingerprinting within three days from the facility receiving their background checks.

C. Based on interview and record review the facility failed to review the security measures listed in the Identified Offender Report and Recommendation provided from the state police and failed to specifically address the identified offender's needs in an individualized plan of care for one of 47 residents (R37) reviewed for background checks in a sample of 76).

Findings include:

The facility's Identified Offender Policy and Procedure documents, "Policy Statement: It is the policy of this facility to establish a resident sensitive and resident secure environment. In accordance with the provisions of the Nursing Home Care Act, this facility shall check the criminal history background on any resident seeking admission to the facility in order to identify previous criminal convictions. It is the policy of (the facility) that no person will be admitted if they are sex offenders. Responsibility: Administrator or a person designated by the

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S9999	Continued From page 15 Administrator. Identifying Offenders: 3. Conduct a Criminal History Background Check: Within 24 hours of admission, request a name-based Uniform Conviction Information ACT (UCIA) criminal history background check based on name, date of birth, and other identifiers required by the Department of State Police for any resident seeking admission to the facility. 4. Check the UCIA response against the statue citation numbers from IDPH (Illinois Department of Public Health) identified offender conviction list and the IDPH sex offenses list. b. If the UCIA response contains convictions that match the identified offender or sex offender statute citation numbers, the resident is an identified offender and must be reported to Identified Offenders Program. Reporting Results If the Resident is an Identified Offender: 1. Once the facility determines the resident is an Identified Offender, the facility must request in 72 hours for the resident to undergo a live scan State and Federal Bureau of Investigation (FBI) fingerprint check within five business days. 2. Immediately complete and submit the IDPH Identified Offender Information (IOI) form attached and fax it to the IDPH Identified Offender Program (IOP) along with a copy of the UCIA response. 4. After the confirmation from the (IOP), the facility will receive a phone call from the Illinois State Police Division of Internal Investigation within three business days scheduling an on-site facility interview with the resident and the administrator. 6. The facility will receive an Identified Offender Report and Recommendations within four to six weeks. The identified Offender Report Recommendations shall detail whether and to what extent the Identified Offender's criminal history necessitates the implementation of security measure with the long-term care facility. The Identified Offender Report and	S9999		

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Recommendations shall be incorporated into the facility's plan of care. Maintain written documentation of compliance with the above requirement.

The Illinois Department of Public Health (IDPH) Identified Offenders Program Criminal History Analysis Security Recommendation Report (undated) documents, "High Risk-The resident requires a single room in close proximity to the nursing station to permit ongoing visual monitoring. The level of observation should be sufficient for early detection of behavioral changes. Regular assessment is necessary to determine whether closer monitoring or more frequent individual contact is indicated. Moderate Risk-The resident requires closer supervision and more frequent observation than standard or routine for most residents in an open facility. Regular monitoring should be attentive to behavioral changes that may signal a need for closer observation or sustained visual monitoring on a time-limited basis. Periodic assessments should ascertain whether the level of supervision is sufficient. Low Risk-the resident is subject to standard requirements for supervision in an open facility. Behavioral changes suggesting a need for closer observation should be noted and responded to according to standard facility procedures."

R37's IDPH Identified Offender Program Criminal History Analysis Security Recommendation Report dated 10-5-18 and signed by V55 (Clinical Psychologists) and V56 (Clinical Psychologists) documents, "(R37) is high risk. (R37) has convictions for violate order protection, retail theft offenses three times, disorderly conduct, domestic battery/bodily harm, and possession liquor by minor. (R37) has a history of substance

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S9999	Continued From page 17 abuse and many physical difficulties as the result of a traumatic brain injury. (R37) is dysphagic, paraplegic, and uses a wheelchair to ambulate. Since his admission (to another facility) on August 27, 2018, he has been both verbally and physically aggressive. He has been involved in verbal altercations with other residents and threw a urinal full of urine on another resident. He had threatened to kill his roommate as he felt he was stealing from him. He has been verbally aggressive at his last placement at (another long-term care facility). His compliance with medical treatment and abstinence from alcohol/drug use should be closely monitored. I would deem (R37) a high risk due to verbal aggression, threats to kill another resident, and his throwing a urinal at another resident." R37's Face Sheet documents R37 was admitted to the facility on 12-4-23. R37's Care Plan dated 12-4-23 to 2-5-24 does not include a plan of care to address R37 being a high risk identified offender with the recommendations as documented on R37's IDPH Identified Offender Program Criminal History Analysis Security Recommendation Report dated 10-5-18. R37's current care plan does not include a plan of care that addresses the identified offender risks and interventions to address those risks. On 2-6-24 at 11:12 AM V30 (Care Plan Coordinator) and V31 (MDS/Minimum Data Set Coordinator) both confirmed that R37's care plan did not include R37's Identified Offender Report and Recommendation provided from the state police to specifically address the identified offenders needs.	S9999		

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D.) Based on observation, record review, and interview the facility failed to protect residents (R1, R3, R5) from verbal, mental, and physical abuse from another resident (R2) for three of four residents (R1, R3, R5) reviewed for abuse in the sample of 76. This failure resulted in R2 spitting on R1 on multiple occasions, pouring water over R1's head, cursing at R1 on multiple occasions days before R2 physically assaulted R1 by kicking and stomping R1 in the face which resulted in R1 sustaining lacerations to the nose and left eyelid, head trauma, bruising around the left eye, a hematoma under the left eye, severe pain, and mental anguish that required emergency room care for treatment.

Findings include:

1. R2's Admission Summary dated 6-7-23 documents, "This 40-year-old African American was admitted to (facility) from (another long-term care facility). Unaware of time, date, and facility. Ambulates on own. Diagnosis: Bipolar Disorder current episode manic without psychotic features and TBI (Traumatic Brain Injury).

R2's Progress Notes dated 11-1-23 at 10:52 PM and signed by V24 (RN/Registered Nurse) documents, "(R2) reportedly spitting multiple times on peers today."

R2's Progress Notes dated 11-12-23 at 12:35 PM and signed by V24 (RN) documents, "(R2) reportedly spit on a peer today. Re-directed and behavior not reported by peer again."

R1's BIMS (Brief Interview of Mental Status) dated 11-10-23 documents R1 is cognitively intact.

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R1 and R2's Final Report dated 1-25-24 documents on 1-25-24 R1 stated she was on the floor close to R2's room when R2 approached R1 and kicked her.

R1 and R2's Police Report dated 1-25-24 at 3:37 PM documents, "Event: Battery. Complainant: V4 (AIT/Administrator-In-Training). Victim: (R1). Suspect: (R2). (R2) kicked another resident (R1) in the head."

R1's Progress Notes dated 1-25-24 at 5:42 PM and signed by V11 (LPN/Licensed Practical Nurse) AIM (Acute Illness Management) for Wellness Event Record documents, "(R1) appears to have sustained an injury that was unwitnessed. Event was first noted on 1-25-24 at 4:00 PM. Evaluation of the resident and event occurred on or about 1-25-24 at 4:01 PM. Just prior to/at the time of the event (R1) appears to have been sitting on floor. (R1's) account of the event is "I was on the floor and (R2) kicked me in my head." (R1) was asked to point out the residents who allegedly kicked (R1) then pointed to (R2). Staff's response is noted as assessing (R1) who reportedly received a kick to their face. (R1) rates pain level as an eight. Vocal complaints of pain at the time of the event. Pain location includes head pain and headache. (R1) sent to the emergency room for evaluation."

R1's Hospital Emergency Department Notes dated 1-25-24 document, "(R1) was involved in altercation at the (facility) she suffered a contusion to her face. She has some bruising of the lateral aspect of her face and her bridge (of her nose) has been applied some steri-strips. (R1) states she was kicked in the face. Chief Complaint: Head injury and assault victim."

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R2's current Care Plan does not include interventions addressing R2 spitting on other residents, addressing R2 targeting R1, and addressing R2 kicking R1 in the face on 1-25-24.

R1's current Care Plan does not include interventions to protect R1 from R2's past behaviors of spitting on R1 and cursing R1.

On 1-29-24 at 10:30 AM R1 was sitting in a recliner in the sitting area across from the nurses' desk. R1's left eye was surrounded with golf-ball sized purple bruising with a 3 cm (centimeter) by 1 cm hematoma beneath the left eye. R1 had a 3 cm laceration to the left eyelid that was approximated with steri-strips. R1 had a 1 cm laceration to the right side of her nose that was approximated with a steri-strip. R1 stated, "I was sitting on the floor in my doorway and (R2) came up and kicked me three times in the face and then stomped on me. It hurt really bad. I grabbed (R2's) leg and yelled for help. (R2) threw water on me the day before and spits on me. I was abused. I was scared of (R2). (R2) always walked by me and would call me bad names."

On 1-29-24 at 11:20 AM V11 (LPN) stated, "I was working on 1-25-24 and a CNA (Certified Nursing Assistant) reported to me that (R2) kicked (R1) in the face. (R1) was sitting on the floor in her doorway, which she prefers. (R1) was bleeding form her face. I sent (R1) to the emergency room. (R1) was sent back from the emergency room with steri-strips to her lacerations. (R1) knows what is going on and tells the truth. (R1) reported that (R2) kicked her in the face and spit on her. I am not sure if any other behavior interventions have been implemented after (R2) kicked and spit on (R1). I am not sure of any

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behavior interventions to keep (R2) from spitting, (R2) has a lot of aggressive behaviors and has a history of spitting on (R2) and other residents. (R2) calls (R1) a b***h. I have reported to (V1 Administrator-In-Training) that (R2) spits on staff and other residents."

On 1-29-24 at 1:00 PM V26 (Unit Aide) stated, "(R2) cusses at (R1) all the time and spits on (R1). (R2) also spit on me so bad I had to change my shirt."

On 1-29-24 at 1:10 PM V27 (LPN) stated, "(R1) knows what is going on and did not deserve to be kicked by (R2). I know (R2) spits on other residents. (R2) gets agitated very easily."

On 1-29-24 at 1:20 PM V28 (CNA) stated, "(R2) spits on (R1) and has poured water over her head. (R1) does not lie. (R1) knows exactly what happened. (R1) did get kicked in the face by (R2). (R2) will yell at (R1) f**k you b***h!"

On 1-29-24 at 1:55 PM V31 (MDS Coordinator) stated, "I am responsible for (R2's) care plan. (R2) has not had an intervention developed to address (R2) spitting on other residents or staff. (R2) has not had any additional behavior interventions developed after kicking (R1) in the face."

On 1-30-24 at 10:30 AM, V23 (CNA) stated, "I was working on 1-25-24 when (R2) kicked (R1) in the face. I was in the bathroom and heard a kicking sound. I heard (R2) kick and (R1) yelling. I came out and (R1) was in sitting on the floor with her head down, crying, with blood dripping. (R1's) head was bloody and (R1) was in a lot of pain and was screaming "Get her (R2) away from me!" (R2) was standing next to (R1). (R1) was

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terrified and crying. (R1) was sent to the emergency room. (R1) is of sound mind and knows exactly what happened. I feel really bad for (R1). (R1) is a sweetheart. (R1) is never aggressive. (R1) would not make anything up and I could tell she had been kicked in the face by (R2). (R1) always prefers to sit on the ground in her doorway. (R2) has a history of spitting on (R1) and calling (R1) a b***h. (R2) has also thrown water on (R1). (R2) gets mad at (R1) because they share a bathroom, and their rooms are side by side. When (R1) returned from the hospital, staff had to directly supervise (R2) until (R1) was moved off of the unit on 1-26-24. Every time (R2) would walk by (R1) after (R1) was kicked, (R1) would yell, "Get her (R2) away from me." (R1) continued to be terrified when she would see (R2)."

On 1-30-24 at 12:15 PM V24 (Agency RN) stated, "Both times I charted on (R2) spitting on her peers (11-1-24 and 11-12-24), I had witnessed (R2) spit on (R1). I reported both occurrences to V25 (Prior Administrator) as abuse. (R2) would get angry at (R1) because they shared a bathroom and would spit on (R1) and call (R1) a b***h. (R1) would cry and yell out. (R1) was scared of (R2). I do not recall (R1) or (R2) ever being separated. (R1) and (R2) continued to share a bathroom after (R2) would call (R1) names and spit on (R1). (R2) has anger issues and if other residents would not give them their soda, (R2) would call them b*****s. (R2) would call (R1) a b***h quite a bit."

On 1-30-24 at 1:50 PM V14 (Social Service Assistant) stated, "(R1) always sits on the floor in her doorway. (R1) is care planned that she prefers to sit on the floor. (R1) sat on the floor at home. (R1) reported to me that when (R1) was

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sitting in the doorway of her room, (R2) went up to her and kicked her in the face. (R1) knows what is going on. (R1) and (R2) have always shared a bathroom and I think that is why (R2) targets (R1). Administration is aware of (R2's) behaviors. (R2) throws tantrums. I am not aware of any interventions implemented to address (R2) spitting in resident faces or throwing water on them. I am not aware of any new behavior interventions to address (R2's) behaviors after (R2) kicked (R1) in the face."

2. R3's BIMS dated 11-9-23 documents R3 is cognitively intact.

On 1-29-24 at 11:05 AM R3 was well-groomed and alert and orientated. R3 stated, "(R2) always asks me for a phone to call her brother. I do not have a phone. If I do not give (R2) a phone she calls me a b***h. (R2) spit on me a month ago in the dayroom. (R2) called me a b***h yesterday. (R2) calls me a b***h about three to four times a week. I am tired of it. (R2) has also hit me in the cheek because I would not give her my soda. I try to stay away from her. Next time (R2) touches me I will hit her back!"

On 1-29-24 at 1:40 PM V29 (CNA) stated, "I witnessed (R2) hit (R3) in the cheek a few months ago. (R2) wanted (R3's) pop. When (R3) wouldn't give (R2) her pop, (R2) hit (R3) in the cheek. (R3) had a red mark on her cheek."

3. R5's BIMS (Brief Illness of Mental Status) evaluation dated 11-14-23 documents resident is cognitively intact.

On 1-29-24 at 12:45 PM R5 was lying flat in his bed. R5 was groomed appropriately, and no odors were noted. V4 (AIT) was in R5's room.

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R5 stated, "Around a month ago this black lady (R2) and I got into an argument in the hallway. (R2) called me a little b***h and calls other residents b*****s. (R2) is very mean. Right when I turned around R2 hit me in the back of my head. (R2) has anger issues and I am scared to even be around her. I sit in my room a lot to stay far away from her because you never know when she will just go off."

The facility's Abuse Prevention Program Policy dated 11/28/2016 documents, "This facility affirms the right of our residents to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined below. This facility therefore prohibits mistreatment, exploitation, neglect, or abuse of its residents, and have therefore prohibits mistreatment, exploitation neglect or abuse of its residents, and has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of mistreatment, exploitation, neglect, or abuse of our residents. This will be occurrences of mistreatment exploitation, neglect, or abuse of our residents. This will be done by: Establishing an environment that promotes resident sensitivity, resident security, and prevention of mistreatment, exploitation, neglect, and abuse of residents and misappropriation of resident property. Identifying occurrences and patterns of potential mistreatment, exploitation, neglect, and abuse of residents and misappropriation of resident property."

E.) Based on observation, interview, and record review the facility failed to implement their Abuse policy by failing to protect multiple residents from verbal, physical, and mental abuse from another

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resident (R2), failing to provide adequate supervision of (R2) to prevent (R2) from further abusing other residents, failing to investigate and report to the state surveying agency multiple reports of resident-to-resident abuse, failed to thoroughly investigate resident-to resident abuse allegations, and failing to notify the police of resident-to-resident abuse for three of four residents (R1, R3, and R5) reviewed for abuse in the sample of 76. These failures resulted in R2 (alleged perpetrator) having continued unsupervised access to all residents residing within the alarmed unit after R2 physically assaulted R1 by spitting on R1 on multiple occasions, cursing at R1 on multiple occasions, kicking and stomping R1 in the face, striking R3 in the face, striking R5 in the back of the head, and pushing R5 backwards. These failures have the potential to affect all residents (R3, R5, R12-R47) residing within the alarmed unit that R2 resides.

Findings include:

R2's Admission Summary dated 6-7-23 documents, "This 40-year-old African American was admitted to (facility) from (another long-term care facility). Unaware of time, date, and facility. Ambulates on own. Diagnosis: Bipolar Disorder current episode manic without psychotic features.

R2's Order Summary Report dated 1-29-24 documents R2 has the diagnoses of Bipolar Disorder, Episode Manic Without Psychotic Features, and anxiety disorder.

R2's Social Services Note Late Entry dated 9-5-23 at 10:08 AM and signed by V26 (Prior Social Service Director) documents, "(R2) was involved in an alleged altercation with a female

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peer (R3) on 9-4-23."

R3's BIMS dated 11-9-23 documents R3 is cognitively intact.

R2's Progress Notes dated 11-1-23 at 10:52 PM and signed by V24 (RN/Registered Nurse) documents, "(R2) reportedly spitting multiple times on peers today."

R2's Progress Notes dated 11-12-23 at 12:35 PM and signed by V24 (RN/Registered Nurse) documents, "(R2) reportedly spit on a peer today. Re-directed and behavior not reported by peer again."

R2's Progress Notes dated 11-30-23 through 12-2-23 documents on 11-30-23 R2 had an alleged physical altercation with a peer in the common area.

R2's AIM (Acute Illness Management) for Wellness Event Record dated 1-6-24 at 5:05 PM and signed by V11 (LPN) documents, "(R2) appears to have been involved in an altercation with a peer (R5). Just prior to/at time of the event (R2) appears to have been in the dining room. (R2's) papers states (R2) punched (R5) in the back of the head because he would not share his soda."

R5's BIMS (Brief Illness of Mental Status) evaluation dated 11-14-23 documents resident is cognitively intact.

R1 and R2's Final Report dated 1-25-24 documents on 1-25-24 R1 stated she was on the floor close to R2's room when R2 approached R1 and kicked her. This same investigation provided by V4 (Administrator-In-Training/AIT) does not

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include any staff statements regarding the incident.

R2's current Care Plan does not include interventions addressing R2 spitting on other residents, addressing R2 targeting R1, and addressing R2 kicking R1 in the face on 1-25-24.

R1's BIMS (Brief Interview of Mental Status) dated 11-10-23 documents R1 is cognitively intact.

R1's Progress Notes dated 1-25-24 at 5:42 PM and signed by V11 (LPN/Licensed Practical Nurse) AIM (Acute Illness Management) for Wellness Event Record documents, "(R1) appears to have sustained an injury that was unwitnessed. Event was first noted on 1-25-24 at 4:00 PM. Evaluation of the resident and event occurred on or about 1-25-24 at 4:01 PM. Just prior to/at the time of the event (R1) appears to have been sitting on floor. (R1's) account of the event is "I was on the floor and (R2) kicked me in my head." (R1) was asked to point out the residents who allegedly kicked (R1) then pointed to (R2). Staff's response is noted as assessing (R1) who reportedly received a kick to their face. (R1) rates pain level as an eight. Vocal complaints of pain at the time of the event. Pain location includes head pain and headache. (R1) sent to the emergency room for evaluation."

R1's Hospital Emergency Department Notes dated 1-25-24 document, "(R1) was involved in altercation at the (facility) she suffered a contusion to her face. She has some bruising of the lateral aspect of her face and the bridge (of her nose). Applied some steri-strips. (R1) states she was kicked in the face. Chief Complaint: Head injury and assault victim."

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R1's Health Status Notes dated 1-25-24 at 9:49 PM documents, "(R1) presenting with discoloration around the left periorbital area. Wound present on left side of face above left eyelid. Wound present on right side of nose. Wound dressed with steri-strips. Will continue to monitor."

On 1-29-24 at 10:30 AM R1 was sitting in a recliner in the sitting area across from the nurse's desk. R1's left eye was surrounded with golf-ball sized purple bruising with a 3 cm (centimeter) by 1 cm hematoma beneath the left eye. R1 had a 3 cm laceration to the left eyelid that was approximated with steri-strips. R1 had a 1 cm laceration to the right side of her nose that was approximated with a steri-strip. R1 stated, "I was sitting on the floor in my doorway and (R2) came up and kicked me three times in the face and then stomped on me. It hurt really bad. I grabbed (R2's) leg and yelled for help. (R2) threw water on me the day before and spits on me. I was abused. I was scared of (R2). (R2) always walked by me and would call me bad names."

On 1-29-24 at 11:05 AM R3 was well-groomed and alert and orientated. R3 stated, "(R2) always asks me for a phone to call her brother. I do not have a phone. If I do not give (R2) a phone she calls me a b***h. (R2) spit on me a month ago in the dayroom. (R2) called me a b***h yesterday. (R2) calls me a b***h about three to four times a week. I am tired of it. (R2) has also hit me in the cheek because I would not give her my soda. I try to stay away from her. Next time (R2) touches me I will hit her back!"

On 1-29-24 at 12:45 PM R5 was lying flat in his bed. R5 was groomed appropriately, and no

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odors were noted. V4 (AIT) was in R5's room. R5 stated, "Around a month ago this black lady (R2) and I got into an argument in the hallway. (R2) called me a little b***h and calls other residents b*****s. (R2) is very mean. Right when I turned around R2 hit me in the back of my head. (R2) has anger issues and I am scared to even be around her. I sit in my room a lot to stay far away from her because you never know when she will just go off."

On 1-29-24 from 1:10 PM through 1:45 PM and on 1-30-24 from 11:00 AM through 11:45 AM R2 was walking around without staff supervision throughout the hallways, dining room, and sitting area. All other residents who reside on the same unit (R3, R5, R12-R47) as R2 were in the dining room, sitting area, and hallways where R2 was wandering around unsupervised.

On 1-29-24 at 11:20 AM V11 (LPN/Licensed Practical Nurse) stated, "I was working on 1-25-24 and a CNA (Certified Nursing Assistant) reported to me that (R2) kicked (R1) in the face. (R1) was sitting on the floor in her doorway, which she prefers. (R1) was bleeding form her face. I sent (R1) to the emergency room. (R1) was sent back from the emergency room with steri-strips to her lacerations. (R1) knows what is going on and tells the truth. (R1) reported that (R2) kicked her in the face and spit on her. We put direct supervision of staff on (R2) after she kicked (R1), until the next day when (R1) returned to the facility. (R1) was moved to a different unit. I am not sure if any other behavior interventions have been implemented after (R2) kicked and spit on (R1). I am not sure of any behavior interventions to keep (R2) from spitting, (R2) has a lot of aggressive behaviors and has a history of spitting on (R1) and other residents. (R2) has also spit on

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me and (V21/Unit Aide). (R2) calls (R1) a b***h. (R2) has also punched (R5) in the back of the head. I have reported to (V1 AIT/Administrator-In-Training) that (R2) spits on staff and other residents. (R2) is allowed to roam and be around all of the residents on this unit (R3, R5, 12-R47). This unit is alarmed at the doors and (R2) is not allowed to leave this unit."

On 1-29-24 at 1:10 PM V27 (LPN) stated, "(R1) knows what is going on and did not deserve to be kicked by (R2). I know (R2) spits on other residents. (R2) gets agitated very easily."

On 1-29-24 at 1:20 PM V28 (CNA) stated, "(R2) spits on (R1) and has poured water over her head. (R1) does not lie. (R1) did get kicked in the face by (R2). (R2) will yell at (R1) f**k you b***h! (R2) is always cussing at the residents. We try to re-direct (R2) as much as possible. (R2) roams the hallways of this closed unit and is able to be around all of the residents on this unit."

On 1-29-24 at 1:40 PM V29 (CNA) stated, "I witnessed (R2) hit (R3) in the cheek a few months ago. (R2) wanted (R3's) pop. When (R3) wouldn't give (R2) her pop, (R2) hit (R3) in the cheek. (R3) had a red mark on her cheek."

On 1-29-24 at 1:55 PM V31 (MDS/Minimum Data Set Coordinator) stated, "I am responsible for (R2's) care plan. (R2) has not had an intervention developed to address (R2) spitting on other residents or staff. (R2) has not had any additional behavior interventions developed after kicking (R1) in the face."

On 1-29-24 at 5:10 PM V13 (LPN) stated, "(R1) has been scared of (R2) for quite some time now. (R2) spits on staff and other residents. (R1) is

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completely alert and would be able to tell the truth if she was kicked in the face by (R2). (R5) is also alert and would also know if (R2) hit him in the head. (R2) has a fight or flight attitude."

On 1-30-24 at 11:15 AM V1 (Administrator-In-Training) stated, "Residents spitting on other residents is abuse. I have no evidence of investigations being completed or reported to IDPH (State Agency) for the allegations of (R2) spitting on her peers."

On 1-30-24 at 12:15 PM V24 (Agency RN/Registered Nurse) stated, "I have not worked at the facility for about one month. Both times I charted on (R2) spitting on her peers, I had witnessed (R2) spit on (R1). I reported both occurrences to V25 (Prior Administrator) as abuse. (R2) would get angry at (R1) because they shared a bathroom and would spit on (R1) and call (R1) a b***h. (R1) would cry and yell out. (R1) was scared of (R2). I do not recall (R1) or (R2) ever being separated. (R1) and (R2) continued to share a bathroom after (R2) would call (R1) names and spit on (R1). (R2) has anger issues and if other residents would not give her their soda, (R2) would call them b*****s. (R2) would call (R1) a b***h quite a bit. (R2) is able to roam the hallways of the unit and is not separated from any of the residents."

On 1-30-24 at 1:50 PM V14 (Social Service Assistant) stated, "(R1) always sits on the floor in her doorway. (R1) is care planned that she prefers to sit on the floor. (R1) sat on the floor at home. (R1) reported to me that when (R1) was sitting in the doorway of her room, (R2) went up to her and kicked her in the face. (R1) knows what is going on. (R2) spits on other residents and throws water on other residents.

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Administration is aware of (R2's) behaviors. (R2) throws tantrums. I am not aware of any interventions implemented to address (R2) spitting in other resident's faces or throwing water on them. After (R2) kicked (R1) in the face, we put direct supervision on (R2) until the next morning when we moved (R1) off of the unit. After the next morning, (R2) was no longer directly supervised. I am not aware of any new behavior interventions to address (R2's) behaviors after (R2) kicked (R1) in the face. (R2) walks around the hallways and dining room of this unit."

On 1-31-24 at 7:24 AM V25 (Prior Administrator) stated, "I do not remember anyone reporting to me that (R2) was spitting on other residents. I never did an abuse investigation about (R2) spitting on other residents or contacted the police. I would consider spitting on other residents a form of abuse."

On 1-31-24 at 11:05 AM V4 (Administrator in Training) stated, "When I completed my investigation for the alleged allegation between R1 and R2 on (1-25-24), I did not interview any staff members beside the reporting nurse V11 (LPN) on the unit that R1 and R2 were on to see if they had witnessed the altercation."

The facility's Abuse Prevention Program Policy dated 11/28/2016 documents, "This facility affirms the right of our residents to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined below. This facility therefore prohibits mistreatment, exploitation, neglect, or abuse of its residents. and have therefore prohibits mistreatment, exploitation neglect or abuse of its residents and has attempted to establish a resident sensitive and

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resident secure environment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of mistreatment, exploitation, neglect, or abuse of our residents. This will be occurrences of mistreatment exploitation, neglect, or abuse of our residents. This will be done by: Establishing an environment that promotes resident sensitivity, resident security, and prevention of mistreatment, exploitation, neglect, and abuse of residents and misappropriation of resident property. Identifying occurrences and patterns of potential mistreatment, exploitation, neglect, and abuse of residents and misappropriation of resident property; Dementia management and resident abuse prevention. Immediately protecting residents involved in identified reports of possible abuse; Implementing systems to investigate all reports and allegations of mistreatment, exploitation, neglect, abuse of residents and misappropriation of resident property; promptly and aggressively and making the necessary changes to prevent future occurrences. The facility is committed to protecting our residents from abuse by anyone including, but not limited to, facility staff, other residents, consultants, volunteers, and staff from other agencies providing services to the individual, family members or legal guardians, friends, or any other individuals. Abuse: Abuse is the willful injection of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents irrespective of any mental or physical condition, cause physical harm, pain or mental abuse including abuse facilitated or enabled through the

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use of technology. Willful, as used in this definition abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Physical Abuse includes hitting, slapping, pinching, kicking, and controlling behavior through corporal punishment. Verbal Abuse is the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or families, or within their hearing distance regarding of their age, ability to comprehend, or disability. Examples of verbal abuse include, but are not limited to, threats of harm, or saying things to frighten a resident, such as telling a resident that he/she will never to be able to see his/her family again. Serious Bodily Injury: an injury involving extreme physical pain; involving substantial risk of death; involving protracted loss or impairment of the function of a bodily member, organ, or mental faculty; or requiring medical intervention such as surgery, hospitalization, or physical rehabilitation; Employees are required to immediately report any occurrences of potential/alleged mistreatment, exploitation, neglect, and abuse of residents and misappropriation of resident property they observe, hear about, or suspect to a supervisor and the administration. Upon learning of the report, the administrator or designee shall initiate an investigation. The facility will take steps to prevent mistreatment, exploitation, neglect, and abuse of any residents and misappropriation of resident property while the investigation is underway. Residents who allegedly mistreat or abuse another resident or misappropriate resident property will be removed from contact with that resident during the course of investigation. The accused resident's condition shall be immediately evaluated to determine the most suitable therapy, care approaches and

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placement considering his or her safety, as well as the safety of other residents and employees of the facility. Following the Resident Protection Investigation Procedures. The appointed investigator will follow the Resident Protection Investigation Procedures, attached to this policy. The Procedures contain specific investigation paths depending on the nature of the allegation, procedures for investigation, interview parameters, and reporting requirements. Final Investigation Report. The investigator will report the conclusions of the investigation in writing to the administrator or designee within five working days of the reported incident. External Reporting of Potential Abuse: 1. Initial Reporting of Allegations. The facility must ensure that all alleged violations involving mistreatment, exploitation, neglect, or abuse, including injuries from unknown source, misappropriation of resident property, and reasonable suspicion of a crime, are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures. If the events that cause the reasonable suspicion result in serious bodily injury or suspected criminal sexual abuse, the report shall be made to at least on law enforcement agency of jurisdiction and IDPH (Illinois Department of Public Health) immediately after forming the suspicion (but not later than two hours after forming the suspicion), Otherwise, the report must be made no later than 24 hours forming the suspicion. A written report shall be sent to the Department of Public Health. The written report should contain the following information, if known at the time of report; Name, age, diagnosis and mental status of the resident allegedly abused or neglected; Type of abuse reported (physical, sexual, theft, neglect, exploitation, verbal or mental abuse); Date, time,

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S9999	Continued From page 36 location and circumstances of the alleged incident; Any obvious injuries or complaints of injury; and, Steps the facility has taken to protect the resident. Five-day Final Investigation Report. Within five working days after the report of the occurrence a complete written report of the confusion of the investigation, including steps the facility has taken in response to the allegation, will be sent to the department of Public Health. The Public Health requirements for a final investigation report are detailed in paragraph five of the Internal Investigations section of this procedure. Investigation Procedures: Regardless of the specific nature of the allegation (physical, sexual, verbal/exploitation/mental, theft, or neglect), the investigation shall consist of: A review of the initial written reports; Completion of a written report on the status of the investigation of the occurrence; An interview with the person(s) reporting the incident; Interviews with any witnesses to the incident; An interview with the resident; Where appropriate, an interview with the resident's attending physician or psychiatrist; A review of the medical records of any resident involved in the occurrence; If the accused individual is an employee, review the personnel file to check for references, background check, and documentation of orientation and training; An interview with staff members having contact with the resident and accused individual during the period of the alleged incident; Where appropriate, interviews with the resident's roommate, family members, visitors or others who were in the vicinity of the incident; Interviews with other residents to which the accused individual has regular contact; Interview other employees to determine if they have ever witnessed other incidents of mistreatment involving the accused individual; Obtain address, phone number and social security number of the accused individual;	S9999		

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An interview with the accused individual or individuals (with a witness present); and a review of all circumstances surrounding the incident."

F.) Based on record review and interview the facility failed to document all measures the facility took to meet R2 and R11's behavioral and mental health needs that could not be met by the facility, failed to develop and implement behavioral interventions and care plans to meet those behaviors, failed to document the specific services the receiving facility will provide to meet R2 and R11's needs which could not be met by the facility, prior to discharging R2 to another long-term care facility, failed to notify R2's Physician of R2's discharge and R11's emergency discharge, and failed to allow R11 to remain in the facility while a discharge appeal was pending for two of three residents (R2 and R11) reviewed for discharge in the sample of 76. These failures resulted in R2 being transferred back to the same long-term care facility (name of facility) that was unable to meet R2 behavioral needs prior to admission to this facility and R2 experiencing increased anxiety and behaviors after being transferred to the accepting facility on 1-30-24. These failures also resulted in R11 being involuntarily discharged on 1-23-24, before R11's scheduled discharge appeal date of 1-30-24, to a homeless shelter that could not accommodate R11's wheelchair, where R11 has been sleeping on the floor causing R11 excruciating back pain, having major chest pain, having increased anxiety, having increased anger, having fearfulness of not finding adequate housing, and being unable to find transportation to doctor appointments from the homeless shelter.

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Findings include:

1. R2's Pre-Admission Referral Packet including R2's Care Plan and Progress Notes dated 4-28-23 through 5-23-23 that was provided to the facility on 6-7-23 from (transferring Long Term Care Facility) documents R2 was exhibiting verbal and physical outbursts, was easily agitated with peers, responded at times with verbal and physical aggression, and was spitting on other people prior to admission to the facility on 6-7-23.

R2's Admission Summary dated 6-7-23 documents, "This 40-year-old African American was admitted to (facility) from (transferring long-term care facility) on 6-7-23. Unaware of time, date, and facility. Ambulates on own. Diagnosis: Bipolar Disorder current episode manic without psychotic features and TBI (Traumatic Brain Injury)."

R2's Progress Notes dated 11-1-23 at 10:52 PM and signed by V24 (RN/Registered Nurse) documents, "(R2) reportedly spitting multiple times on peers today."

R2's Progress Notes dated 11-12-23 at 12:35 PM and signed by V24 (RN) documents, "(R2) reportedly spit on a peer today. Re-directed and behavior not reported by peer again."

R2's Final Report dated 1-25-24 documents on 1-25-24 R1 stated she was on the floor close to R2's room when R2 approached R1 and kicked her.

R2's current Care Plan does not include interventions addressing R2 spitting on other residents, addressing R2 targeting R1, and

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addressing R2 kicking R1 in the face on 1-25-24.

R2's Behavioral Care Solutions for Adults and Seniors Physician's Notes dated 1-13-24, 11-12-23, 10-9-23, and 8-10-23 and signed by V35 (Psychiatric Medical Doctor) all documents R2 has had no prior history of aggression or violence.

R2's Social Services Notes dated 1-30-24 at 2:24 PM and signed by V14 (Social Service Director) documents R2 will be moving to another long-term care facility (back to the Long-Term Care Facility that the resident transferred in from on 6/07/24). This same note does not document the reason for R2's transfer to another facility.

R2's Discharge Summary dated 1-30-24 is incomplete. Section K. Brief Medical History and Section L. Current Treatments and Therapies of R2's Discharge Summary are incomplete and do not include R2's medical history, current treatment, or current therapies.

R2's Care Plan dated 6-7-23 (Admission) through 1-30-24 (Discharge) does not include a comprehensive discharge plan.

R2's Medical Record does not include documentation from the Physician (V34) of the specific needs the facility could not meet, the facility efforts to meet R2's needs, and the specific services the receiving facility will provide to meet the needs of the resident which cannot be met at the current facility.

On 1-29-24 at 1:55 PM V31 (MDS/Minimum Data Set Coordinator) stated, "I am responsible for (R2's) care plan. (R2) has not had an intervention developed to address (R2) spitting on

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other residents or staff. (R2) has not had any additional behavior interventions developed after kicking (R1) in the face."

On 2-2-24 at 8:20 AM V34 (R2's Physician) stated, "I do not know a lot about (R2). I did not know the facility transferred (R2) to another facility. I was not asked to provide (R2's) needs, needs that could not be met by the facility, or the reason for (R2's) transfer."

On 2-2-24 at 11:15 AM V33 (R2's POA) stated, "The facility admitted (R2) from the same facility (transferring Long Term Care Facility) that they just discharged (R2) back to on Wednesday. That facility was not able to manage (R2's) behaviors either. I did not want (R2) to go back to that same facility. I did not even get a chance to decide on whether I was okay for the facility to transfer (R2) to another facility. (R2) had major behaviors when living at that facility before. The facility left messages on my phone and did not get my permission before sending (R2) to another facility. I called the facility and was told they had already transferred (R2) back to the old facility again because (R2) was having behaviors that they facility could not manage. The facility knew (R2) had behaviors when they accepted (R2) that she had major behaviors. (R2's) behaviors is the reason why the prior facility transferred her to this facility. V14 (Social Service Director) told me the facility transferred (R2) to another facility so that (R2) would have a clean medical record regarding (R2's) behaviors and that would allow (R2) to get closer to me eventually. (R2) has had increased behaviors and anxiety the last two days since being sent to the other facility, and (R2) has been blowing up my phone."

On 2-2-24 at 11:30 AM V14 stated, "I tried to call

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(V33) four times on 1-30-24 about the facility transferring (R2) to another facility. (V33) did not answer. The other facility was a safer place for (R2). (V33) called me back the next day on 1-31-24 and I let him know we transferred (R2) to the other facility. (V33) did not really like that (R2) was transferred to the facility that she had was at before." V14 stated she was not aware of any documentation in R2's record of the needs the facility could not provide to R2 or the interventions attempted to meet those needs prior to transferring R2 to another facility."

On 2-2-24 at 11:35 AM V2 (Director of Nursing) stated she was not aware of any documentation in R2's record of the needs the facility could not provide to R2 or the interventions attempted to meet those needs prior to transferring R2 to another facility.

On 2-2-24 at 11:45 AM V18 (Corporate Nurse) stated, "We (the facility) decided to transfer (R2) to another facility because we felt like the other facility could offer (R2) better services for her behaviors." R2's medical record does not have physician documentation of the specific needs the facility could not meet, the facility efforts to meet R2's needs, and the specific services the receiving facility will provide to meet the needs of the resident which cannot be met at the current facility."

On 2-2-24 at 1:35 PM V32 (Regional Ombudsman) stated, "The facility did not inform me that they were transferring (R2) to another facility."

2. R11's Pre-screening/Screening Assessment for Harmful Behaviors dated 12-22-2020 (prior to R11's Admission) documents R11 has a history of

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the following: 1. General behavior appears to integrate manipulative statements including small lies and "stretching the truth" (embellished stories, half-truths, etcetera). 2. Appears to harbor considerable fears concerning issues such as: separation from support system, long term care placement, living in a group situation, being a recipient of care, and prehension regarding the disease or illness. 3. Attempts to make others including caregivers and/or family members feel guilty, ineffective, angry, and/or inadequate. 4. History or active use of addictive substances (example: alcohol abuse) and/or attempts to have doctor prescribe narcotics. Recognize chemical addiction as self-destructive behavior. 5. Non-compliance with medication and treatment regimen and/or makes frequent requests for "order" changes (examples: medications, diet).

R11's current POS (Physician Order Sheet) documents R11 was admitted on 12-22-2020 and has the following, but not limited to, diagnoses: schizoaffective disorder; Bipolar Type, Generalized Anxiety Disorder, Obsessive-Compulsive Disorder, Heart Failure, Low Back Pain, Unspecified Asthma, and Chronic Obstructive Pulmonary Disease. This same form documents R11 receives Buspirone HCL (Hydrochloride) 10mg (milligram) one tablet two times a day for obsessive compulsive disorder and Clonazepam 0.5mg 1 tablet two times a day for Obsessive compulsive disorder.

R11's BIMS (Brief Mental Interview Status) dated 12-19-2023 documents R11 is cognitively intact.

R11's MDS (Minimum Data Set) Assessment dated 12-30-23 documents R3 has exhibited no physical behavioral symptoms directed towards others.

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R11's Progress Notes dated 11-20-23 through 1-17-24 documents the following: On 11-29-23, 12-06-23, 12-07-23, 12-9-23, 12-11-23, 12-27-23, 12-28-23, 1-9-24, 1-10-24, 1-16-24, 1-18-24, 1-22-24, and 1-23-24 R11 had verbal behaviors or arguments directed towards staff. These same notes did not document any behavioral interventions that were attempted for R11's behaviors or if they were effective.

R11's Behavior Monitoring and Interventions Report dated 11-6-23 documents R11 had verbal behaviors and physical behaviors. The only intervention attempted was one on one of staff and the form documents R11's behavior did not change. No other interventions were attempted by staff.

R11's Behavior Monitoring and Interventions Report dated 11-20-23 documents R11 had multiple verbal and physical behaviors and no interventions were attempted by staff.

R11's Behavior Monitoring and Interventions Report dated 12-6-23 documents R11 had verbal behaviors and insomnia and no interventions were attempted by staff.

R11's Behavior Monitoring and Interventions Report dated 12-7-23 documents R11 had verbal behaviors that improved with one-on-one intervention.

R11's Behavior Monitoring and Interventions Report dated 1-17-24 documents R11 had multiple physical and abusive verbal behaviors and no interventions were attempted by staff.

R11's Behavior Monitoring and Intervention

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Report dated 11-1-23 through 1-17-24 documents R11 had no other behaviors within this time frame, except for the behaviors identified above.

R11's Physician Notes dated November 2023, December 2023, and January 2024 and signed by V34 (R1's Primary Physician) does not document any behavioral concerns related to R11.

R11's Progress Note dated 1-23-24 and signed by V18 (Corporate Regional Nurse) documents, "This writer received call from facility Administrator. Reviewed concerns in regard to resident (R11). Reported peer concern during care plan meeting today that (R11) causes such an unpleasant environment with his constant badgering of staff and others that peer has not been coming to meal or activities. Reporting staff concerns related to behavior as (R11) continues to create an environment where staff do not feel safe to work. (R11) continues to call staff racial slurs and other derogatory names. It was reported (R11) also allegedly spat at staff."

R11's Electronic Health Record (EHR) and Care Plan does not document any behaviors of R11 spitting on staff prior to 1-23-24 and does not include behavioral interventions to address R11 spitting on staff on 1-23-24. R11's (EHR) also does not document any interventions or new interventions to address R11 creating an unpleasant environment for staff and/or residents.

R11's Notice of Involuntary Transfer or Discharge and Opportunity for Hearing for Nursing Home Residents form dated 11-20-23 documents an involuntary transfer or discharge issued to R11 on 11-20-23 due to the physical safety of other residents, the facility's staff, or visitors.

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The Department of Public Health State of Illinois form dated 11-30-23 documents, "R11 versus (the facility). On Wednesday, December 6, 2023, at 9:30 AM, a pre-hearing will be held concerning the involuntary transfer or discharge of the Complainant to determine whether the involuntary transfer or discharge is authorized for the reasons specified by the Respondent in the Notice of Involuntary Transfer or Discharge. The hearing will be held via teleconference."

R11's Notice of Involuntary Transfer or Discharge and Opportunity for Hearing Nursing Home Residents form dated 1-23-24 documents an emergency transfer or discharge issued to R11 on 1-23-24 due to the safety of individuals in (the facility) being endangered.

R11's Medical Record does not include documentation from the Physician (V34) of the specific needs the facility could not meet, the facility efforts to meet R11's needs, and the specific services the receiving facility will provide to meet the needs of the resident which cannot be met at the current facility.

R11's Plan of Care dated 11-20-23 through 1-17-24 does not include any new interventions regarding R11's increase in behaviors, including but not limited to, verbal behaviors towards staff, entering staff areas, causing an unpleasant environment for other residents, or spitting on staff prior to R11's initiated involuntary emergency discharge on 1-23-24.

On 1-29-24 at 9:45 AM V1 AIT (Administrator in Training stated (the facility) had to initiate an emergency involuntary discharge to R11 because R11 was spitting on staff and entering staff areas

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without permission, and the facility had several staff walk out because of R11. V1 stated the facility emergency discharged R11 to the (homeless shelter). V1 also stated there was a hearing set on 1-30-24 with (the facility), the judge, and R11 regarding R11's involuntary discharge. (The facility) decided to initiate an emergency involuntary discharge to R11 (prior to the hearing date set on 1-30-24). V1 stated the facility emergently discharged R11 to the (homeless shelter).

On 1-29-2024 at 10:11 AM R4 stated, "I lived on the same hall as (R11) and was never bothered by him. I had never seen (R11) be mean to any other residents."

On 1-29-24 at 10:15 AM V5 CNA (Certified Nursing Assistant) stated, "R11 could be accusatory, but for the most part was easy to deal with."

On 1-29-24 at 10:30 AM V7 CNA stated, "I liked (R11). I did not have any concerns with him. I have never witnessed him do anything physical to anyone."

On 1-29-24 at 2:10 PM V17 (Laundry Aide) stated, "On 1-17-24 (R11) came barging through the laundry room doors wanting to warm his coffee up in the microwave. (R11) is not supposed to be in the laundry area. I kept telling (R11) to get out, get out! (R11) refused to get out so we called for staff to help remove (R11). (R11) was removed by staff. I did not call (R11) any names until I closed the laundry room door. After I closed the door, I called (R11) a dumb b*****d to my co-worker. I do not know what to do for (R11's) behaviors. I have never been trained in de-escalating behaviors or what to do when (R11)

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has behaviors."

On 1-30-24 at 12:40PM R8 stated, "I have never seen R11 be mean to any other resident. R11 did not prevent me from coming out of my room. I always come out to the front lobby to watch television."

On 1-30-24 at 1:55 PM V32 (Regional Ombudsman) stated, "I was aware of (R11's) involuntary discharge from the facility. I submitted an appeal because it was an illegal involuntary discharge. We were supposed to meet with the judge, the facility, and (R11) today regarding the appeal however the facility had already done an emergency involuntary discharge on (R11). I came to the facility on 1-23-24 when the facility was initiating an emergency involuntary discharge to (R11). (R11) was very angry and had tears and did not want to leave. The staff made (R11) leave and called the police. (R11) felt intimidated by the police so he thought it would be better just to go ahead and leave. I was told the reasoning for the emergency involuntary discharge was due to two staff members quitting because (R11) spit on them. (R11) is now living at the (homeless shelter) and is not handling it well. (R11's) anxiety has worsened and he reports being in more pain. The facility should have allowed for the appeal process to be done prior to involuntary discharging (R11)."

On 1-31-24 at 1:10 PM V12 CNA stated, "(R11) was pretty good. He could be very rude to staff, but usually always apologized."

On 1-31-23 at 2:05 PM R10 stated, "I was (R11's) roommate. (R11) did not have any behaviors unless management staff taunted him. (R11) was tired of seeing how the residents were being

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treated at the facility and started to speak up, and the managers did not like it. I never saw (R11) abuse any residents."

On 2-1-24 at 1:15 PM R11 stated, "I lived at (the facility) for three years and have had no issues until (V25 prior Administrator) started to come into me and my roommate's room without my permission. (V25) was taking my roommates items without his permission. I confronted (V25) about it, and (V25) then put his foot in front of my wheelchair and would not let me move forward. I was tired of seeing the way administration was treating other residents, so I started advocating for the other residents and staff did not like it. Staff would laugh at me and treat me like an animal. They were treating me like a dog and making me stay in my room like I was in a prison around there (the facility). When I would say something back to the staff, I was told that staff were quitting because of me and that they would have to discharge me. I had put in an appeal and the facility did not even allow me to meet for the appeal. They decided to hurry up and do an emergency discharge right before the appeal (1-30-24) because their reasoning was staff were quitting because of me. I was forced to leave by the facility calling the police and intimidating me with the police. I had to go to the (homeless shelter). The (homeless shelter) was unable to accommodate my wheelchair to enter the building, I am sleeping on a floor which has caused me to be in excruciating pain due to my lower back. I have had major chest pains, and I am a nervous wreck. I am angry and I am scared I will not find anywhere to live or have transportation to make it to any doctor's appointments. I miss the staff at the facility that treated me good."

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On 2-2-24 at 8:20 AM V34 (R11's Primary Physician) stated, "I did not know the facility involuntarily discharged (R11) to the (homeless shelter). I was not asked to provide (R11's) needs, needs that could not be met by the facility, or the reason for (R11's) transfer. I was unaware that the facility was doing an emergency involuntary discharge due to (R11's) behaviors. I am unable to recall the facility notifying me of any increase behaviors (R11) may have been experiencing or ever writing an order for (R11) to be involuntarily discharged. "

On 2-2-24 at 11:30 AM V14 (Social Service Director) stated, "I had nothing to do with (R11's) discharge. I am not the one who dealt with the situation. I have not updated (R11's) care plan with any new interventions regarding (R11's) behaviors."

On 2-2-24 at 11:35 AM V2 (Director of Nursing) stated she was not aware of any documentation in R11's record of the needs the facility could not provide to R11 or the interventions attempted to meet those needs prior to involuntarily discharging R11 to the (homeless shelter).

On 2-2-24 at 3:27PM V36 CNA stated, "I worked at the facility for five years on and off. The reasoning for leaving was not because of (R11). I do not know why administration is telling people that. I was not there at the time (R11) was discharged. I was there that morning and (R11) was not acting like himself. (R11) seemed off and seemed upset and angry. (R11) had never done anything to me since I have worked there. (R11) could easily be directed when he had behaviors. I do not think (R11) should have been discharged for behaviors. I think (R11) came to our facility because of his behaviors. I walked out

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rights not being protected, staff experiencing burnout and frustration, and residents being involuntarily discharged to a homeless shelter and a long-term care facility that was unable to meet this resident's needs prior to admission. These failures have the potential to affect all 131 residents within the facility.

Findings include:
The facility's Midnight Census form (dated 1-29-24) indicates that 131 residents are currently residing in the facility.

On 2-2-24 at 12:00 PM V2 (Director of Nursing) provided a list that documents 32 residents (R1, R3, R4, R7, R8, R10, R12, R13, R16, R21, R25, R26, R27, R32, R35, R36, R37, R42, R56, R57, R58, R59, R61, R62, R63, R64, R67, R68, R69, R70, R73, R75) have a level two PASRR (Preadmission Screening and Resident Review) indicating R1, R3, R4, R7, R8, R10, R12, R13, R16, R21, R25, R26, R27, R32, R35, R36, R37, R42, R56, R57, R58, R59, R61, R62, R63, R64, R67, R68, R69, R70, R73, and R75 have mental illness requiring specialized mental health services.

R1, R3, R4, R7, R8, R10, R12, R13, R16, R21, R25, R26, R27, R32, R35, R36, R37, R42, R56, R57, R58, R59, R61, R62, R63, R64, R67, R68, R69, R70, R73, and R75's current Care Plans do not include level two PASRR recommendations.

1. R2's Social Services Note Late Entry dated 9-5-23 at 10:08 AM and signed by V26 (Prior Social Service Director) documents, "(R2) was involved in an alleged altercation with a female peer (R3) on 9-4-23."

R2's Progress Notes dated 11-1-23 at 10:52 PM

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because I was being harassed by another staff member because of another staff member and (the facility) did not do anything about it. I don't remember (R11) ever acting bad."

On 2-2-24 at 3:34PM V37 CNA stated, "I have worked at the facility for around six months. (R11) had very few behaviors when I first worked for him. Within the last couple months, I noticed his behaviors were increasing. I believe it was after the involuntary discharge was given to him. I never see (R11) get physical with residents. There was one time a resident was talking to herself and (R11) went up to her and started to be bossy, but that's about it. The facility did not train me or tell me behavioral interventions to deal with (R11's) behaviors besides getting the nurse. I never received any behavioral training. I did not see an individual plan of care that had interventions to help manage (R11's) behaviors. I was not taught any other behavior interventions to deal with (R11)."

On 2-2-24 at 11:45 AM V18 (Corporate Regional Nurse) stated R11's medical record does not have physician documentation of R11's specific needs the facility could not meet, the facility efforts to meet R11's needs, and the specific services the receiving facility will provide to meet the needs of the resident which cannot be met at the current facility.

On 2-4-24 at 11:30AM V1 AIT (Administrator in Training) stated she was only aware of two staff members that quit or threatened to quit because of R11. V1 stated, "(V36 CNA) quit because of him and (V17 Laundry Aide) threatened to quit because of him." V1 was unaware of any other staff members quitting over R11. V1 also stated she is unaware of the resident that (V18

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Corporate Regional Nurse) documented on in R11's progress note on 1-23-24 that was staying in their room and not coming out to meals because of R11.

The facility's Transfer and Discharge Policy and Procedure policy (undated) documents, "It is the policy of (the facility) not to transfer or discharge a resident unless: 1. The transfer or discharge is necessary to meet the resident's welfare, and the resident's welfare cannot be met in the facility. In all cases except the last, documentation in the resident's clinical record shall be required. The residents attending physician must document in the resident's clinical record that the facility cannot provide for the resident's welfare, or that the resident no longer requires the facilities services. Documentation in the resident's clinical record by any physician that the health of other individuals would be endangered is cause for transfer or discharge. Involuntary transfers or discharges. Except for the case of late payment or nonpayment, the facility shall notify the resident and the residents family member, surrogate or representative of the transfer and the reasons for the transfer as stated in the clinical record. Notice of involuntary transfer/discharge shall be on the forms prescribed by Illinois Department of Health. In all other instances of involuntary transfer or discharge the mandated and federal and state 30 day "Notice Transfer or Discharge" will be issued, and the following steps taken: 1. The planned involuntary transfer or discharge shall be discussed with the resident, guardian, residents' representative and/or the person or agency responsible for the resident's placement, maintenance, and care in the facility. 2. The discussion shall be carried out by the

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administrator or his/her designee. The content of the discussion and explanation shall be summarized in writing, including the names of those in attendance. The summary shall be made a part of the residents clinal record. 3. A physicians discharge order shall be obtained in the residents record prior to discharge. 4. Prior to transfer or discharge the Social Service Director shall counsel the resident and summarize the counseling session in the resident's record."

The Facility Assessment Policy dated 10-23-23 documents, "Resident admission based on common diseases, conditions, physical and cognitive disabilities, or a combination of conditions that require complex medical care and condition management. The list below describes residents' that (the facility) accommodates for and regularly manages. Category: Psychiatric/Mood disorder- Psychosis, Hallucinations (auditory), delusions, mental disorder, MR (Mental Retardation) disorder, depression, anxiety, schizoaffective disorder, bipolar disorder, PTSD (Post Traumatic Stress Disorder), behavior requiring interventions, suicidal ideation, hx (history) of substance abuse. Cares provided for the resident population include by are not limited to: Mental health and behavior- Identify and implement interventions to help support individuals with anxiety, cognitive impairment, depression, PTSD, and other psychiatric diagnosis. Support by group and individual therapies, and structured activities. In house psychiatric physician management. Management of medical conditions- Assessment an early identification of problems and change in condition. Management of medical and psychiatric symptoms and conditions. Special Care Needs- Hospice, end of life care, Mental Health Programming. Provide resident-centered-

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Supporting psychosocial needs, building relationships with residents, honoring resident preferences, discussion on individualized resident plan of care, culturally competent care provided, religious preferences acknowledged (if identified), opportunities for social events, prevention of abuse and neglect, identification of hazards and resident risks, family and representative support provided."

G.) Based on observation, interview, and record review the administration failed to develop behavior management policies; failed to perform resident background checks within 24 hours of admission; failed to follow the facility's Identified Offender Policy and Procedure resulting in residents with a history of qualifying identified offender criminal conviction offenses being admitted to the facility for treatment for mental health services, without having an adequate amount of staff or adequate staff training on managing mental health disorders and behaviors, without care planning or acquiring specialized needs services as documented on those residents' PASRR (Pre-Admission Screening and Resident Review) Level II screenings and their pre-admission screenings; failed to ensure resident behavioral health needs were met and behavioral interventions were developed and implemented, failed to ensure the facility's discharge policy was followed, failed to ensure the facility provided adequate direct care staff and social service staff to provide behavioral health needs, failed to ensure a licensed administrator conducted thorough abuse investigations, and failed to ensure residents were protected from abuse. These failures resulted in residents having an unsafe environment, residents exhibiting increased behaviors causing multiple resident to resident abuse altercations, resident

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and signed by V24 (RN/Registered Nurse) documents, "(R2) reportedly spitting multiple times on peers today."

R2's Progress Notes dated 11-12-23 at 12:35 PM and signed by V24 (RN/Registered Nurse) documents, "(R2) reportedly spit on a peer today. Re-directed and behavior not reported by peer again."

The facility's Abuse Log dated November 2023 to current date (February 6, 2024) documents R2 was in a physical altercation with R1 on 1-25-24 and R2 was in a physical altercation with R5 on 1-6-24.

R2's current Care Plan does not include interventions addressing R2 spitting on other residents, addressing R2 targeting R1, and addressing R2 kicking R1 in the face on 1-25-24.

R2's Social Services Notes dated 1-30-24 at 2:24 PM and signed by V14 (Social Service Director) documents R2 will be moving to another long-term care facility.

2. R11's current Face Sheet documents R11 admitted to the facility on 12-22-2020. This same document lists R11 as being his own responsible party.

R11's CHIRP (Criminal History Information Response Process) dated 12-22-2020 documents, "Result: HIT". R11's CHIRP documents several convictions, "Retail theft, possession of cannabis, criminal damage to property, coin machine theft, and theft. The following convictions are included on the identified offender list: Retail theft, Coin machine theft, and theft. Although requested, this was the

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only background check document the facility was able to provide that was completed on R11."

R11's Care Plan dated 11-20-23 to 1-23-24 does not include a plan of care to address R11's CHIRP document indicating R11 was an identified offender.

R11's Medical Record and Business Office Record does not include a request for a live scan State and Federal Bureau of Investigation (FBI) fingerprint check.

R11's Notice of Involuntary Transfer or Discharge and Opportunity for Hearing Nursing Home Residents form dated 1-23-24 documents an emergency transfer or discharge issued to R11 on 1-23-24 due to the safety of individuals in (the facility) being endangered.

3. R37's IDPH (Illinois Department of Public Health) Identified Offender Program Criminal History Analysis Security Recommendation Report dated 10-5-18 and signed by V55 (Clinical Psychologists) and V56 (Clinical Psychologists) documents, "(R37) is high risk. (R37) has convictions for violate order protection, retail theft offenses three times, disorderly conduct, domestic battery/bodily harm, and possession liquor by minor. (R37) has a history of substance abuse and many physical difficulties as the result of a traumatic brain injury. (R37) is dysphagic, paraplegic, and uses a wheelchair to ambulate. Since his admission (to another facility) on August 27, 2018, he has been both verbally and physically aggressive. He has been involved in verbal altercations with other residents and threw a urinal full of urine on another resident. He had threatened to kill his roommate as he felt he was stealing from him. He has been verbally

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aggressive at his last placement at (another long-term care facility). His compliance with medical treatment and abstinence from alcohol/drug use should be closely monitored. I would deem (R37) a high risk due to verbal aggression, threats to kill another resident, and his throwing a urinal at another resident."

R37's Face Sheet documents R37 was admitted to the facility on 12-4-23.

R37's Care Plan dated 12-4-23 to 2-5-24 does not include a plan of care to address R37 being a high risk identified offender with the recommendations as documented on R37's IDPH Identified Offender Program Criminal History Analysis Security Recommendation Report dated 10-5-18.

R2, R4, R7, R8, R13, R17, R21, R25, R26, R32, R42, R56, R64, R66, R68, R69, R70, R71, R73, and R76's Business Office File and Medical Records do not contain evidence of the facility obtaining background checks of these residents since admission to the facility.

On 2-7-24 at 10:15 AM V54 (Business Office Manager) verified R2, R4, R7, R8, R13, R17, R21, R25, R26, R32, R42, R56, R64, R66, R68, R69, R70, R71, R73, and R76 did not have a background check done within 24 hours of their admission.

R3, R27, R34, R36, R54, R57, R59, and R75 UCIA (Uniform Conviction Information Act) background checks document R3, R27, R34, R36, R54, R57, R59, and R75 had a documented hit that would require criminal fingerprinting to be conducted to determine of a resident is high, moderate, or low risk offender. No fingerprinting

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has yet to be conducted for R3, R27, R34, R36, R54, R57, R59, and R75.

The facility's 2023-2024 Identified Offenders List documents R3, R18, R27, R34, R36, R37, R41, R44, R48, R49, R50, R51, R53, R54, R56, R57, R59, and R75 are identified offenders.

R27, R37, R51, and R57's current care plans do not include a plan of care that addresses the identified offender risks and interventions to address those risks.

The facility's Abuse Log dated November 2023 to current date (February 6, 2024) documents R37 was in a verbal altercation with R71 on 2-4-24, R37 was in a physical altercation with R25 on 2-4-24 and was in a physical altercation with R46 on 1-30-24.

The facility's Abuse Log dated November 2023 to current date (February 6, 2024) documents R27 was in a verbal altercation with R25 on 2-2-24.

The facility's Abuse Log dated November 2023 to current date (February 6, 2024) documents R57 had a verbal altercation with R66 on 2-4-24 and 1-10-24 and R57 had a physical altercation with R66 on 12-10-23.

The facility's Abuse Log dated November 2023 to current date (February 6, 2024) documents R35 was in a verbal altercation with R42 on 2-2-24, was in a physical altercation with R73 on 12-18-23, R68 was in a verbal altercation with R72 on 12-15-23, R10 was in a physical altercation with R66 on 12-21-23, R25 was in a physical altercation with R40 on 12-19-23, and R66 was in a verbal altercation with R12 on 1-22-24.

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The facility's Abuse Log dated November 2023 to current date (February 6, 2024) documents R44 was in a verbal altercation with R7 on 12-26-23, R44 was in a physical altercation with R30 on 12-26-23.

On 1-29-24 at 10:30 AM R1 was sitting in a recliner in the sitting area across from the nurse's desk. R1's left eye was surrounded with golf-ball sized purple bruising with a 3 cm (centimeter) by 1 cm hematoma beneath the left eye. R1 had a 3 cm laceration to the left eyelid that was approximated with steri-strips. R1 had a 1 cm laceration to the right side of her nose that was approximated with a steri-strip. R1 stated, "I was sitting on the floor in my doorway and (R2) came up and kicked me three times in the face and then stomped on me. It hurt really bad. I grabbed (R2's) leg and yelled for help. (R2) threw water on me the day before and spits on me. I was abused. I was scared of (R2). (R2) always walked by me and would call me bad names."

On 1-29-24 at 11:05 AM R3 was well-groomed and alert and orientated. R3 stated, "(R2) always asks me for a phone to call her brother. I do not have a phone. If I do not give (R2) a phone she calls me a b***h. (R2) spit on me a month ago in the dayroom. (R2) called me a b***h yesterday. (R2) calls me a b***h about three to four times a week. I am tired of it. (R2) has also hit me in the cheek because I would not give her my soda. I try to stay away from her. Next time (R2) touches me I will hit her back!"

On 1-29-24 at 12:45 PM R5 was lying flat in his bed. R5 was groomed appropriately, and no odors were noted. V4 (AIT) was in R5's room. R5 stated, "Around a month ago this black lady

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(R2) and I got into an argument in the hallway. (R2) called me a little b***h and calls other residents b*****s. (R2) is very mean. Right when I turned around R5 hit me in the back of my head. (R2) has anger issues and I am scared to even be around her. I sit in my room a lot to stay far away from her because you never know when she will just go off."

On 1-29-24 from 1:10 PM through 1:45 PM and on 1-30-24 from 11:00 AM through 11:45 AM R2 was walking around without staff supervision throughout the hallways, dining room, and sitting area. All other residents who reside on the same unit (R3, R5, R12-R47) as R2 were in the dining room, sitting area, and hallways where R2 was wandering around unsupervised.

On 2-6-24 at 9:45 AM R37 was in the room with his roommate R67. R37 was not in a private room as recommended by his IDPH Identified Offender Program.

On 2-6-24 at 10:00 AM V1 (Administrator-In-Training/AIT) provided a list of current staff who have not received behavioral training for mental illness, or CPI (Crisis Prevention and Intervention) Nonviolent Crisis Training. This list documents V1 (AIT), V2 (Director of Nursing), V4 (AIT), V7 (CNA/Certified Nursing Assistant), V8 (CNA), V12 (CNA), V17 (Laundry Aide), V20 (CNA), V24 (Agency RN/Registered Nurse), V25 (Prior Administrator), V30 (Care Plan Coordinator), V37 (CNA), V38 (CNA), V39 (CNA, V40 (CNA), V41 (CNA), V42 (CNA), V43 (Unit Aide), V44 (Unit Aide), V46 (CNA), V47 (CNA), V48 (LPN/Licensed Practical Nurse), V49 (LPN), V50 (Nursing Assistant), V51 (Nursing Assistant), V52 (CNA), V53 (CNA), V54 (CNA), V55 (CNA), V57 (CNA), and V58 (CNA)

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have not received the CPI Nonviolent Crisis Interventions Training.

The facility's Annual Mandatory Training Log dated 1-1-23 through 12-31-23 documents staff should be trained annually on behavior management. This same document indicates no staff has been trained within the last year on behavioral management.

The facility's CNA staffing sheets dated 1-16-24 through 1-22-24 and signed by V4 (Administrator-In-Training/AIT) document the facility did not have the required amount of CNA staff needed according to the facility's minimum staff calculator to meet the needs of the residents. On 1-29-24 at 2:00 PM, V4 (Administrator in Training) confirmed that the daily CNA staffing sheets (dated 1-16-24 through 1-22-24) were accurate and staffing was below (the facility's) minimum requirements based off the staffing calculator utilized to determine staffing needs.

V58's (CNA) Notice of Termination form dated 9-12-23 documents V58 was terminated from employment immediately due to an inappropriate interaction with a resident.

V58's Employee Business File documents V58 was re-hired to the facility on 1-25-24.

On 1-29-24 at 9:45 AM V1 stated (the facility) had to initiate an emergency involuntary discharge to R11 because R11 was spitting on staff and entering staff areas without permission, and the facility had several staff walk out because of R11. V1 stated she did not know R11 was an identified offender and the facility emergency discharged R11 to (homeless shelter).

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On 1-29-24 at 10:05 AM V8 (CNA) stated, "We could use some more staff here. It is hard to get everyone up and dressed and deal with residents' behaviors with the number of staff we have now."

On 1-29-24 at 10:30 AM V7 (CNA) stated, "We do not have enough staff here. Most resident have behaviors or mental health concerns. There is not enough staff to supervise all of the residents with behaviors. The staff here are getting burned out."

On 1-29-24 at 2:00 PM V1 stated she was unaware when she re-hired V58 that V58 had been terminated from employment on 9-12-23 for an inappropriate interaction with a resident.

On 1-29-24 at 2:10 PM V17 (Laundry Aide) stated, "I have never been trained in de-escalating behaviors."

On 1-30-24 at 11:19 AM V59 (LPN/Licensed Practical Nurse) and V60 (LPN) stated they are unaware of any policies readily available to them regarding dealing with mental illness and behaviors.

On 1-31-24 at 2:05 PM R10 stated, "I had a camera I wanted to use so the facility could see how staff was treating me and my roommate (R11). (V25/Prior Administrator) came into my room and took my camera without my permission. I have not seen the camera since. I bought the camera with my own money. I have my own hot spot on my phone that I can use for Wi-Fi connection. I do not need the facility's Wi-Fi. (V25) never offered to have me sign a consent form to use the camera. I would have signed the consent form so I can use my camera.

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The facility will try anything in their ability to allow me to not be able to use my camera."

On 2-1-24 at 1:15 PM R11 stated, "I lived at (the facility) for three years and have had no issues until (V25/prior Administrator) started to come into me and my roommate's room without my permission. (V25) was taking my roommates items without his permission. I confronted (V25) about it, and (V25) then put his foot in front of my wheelchair and would not let me move forward. I was tired of seeing the way administration was treating other residents, so I started advocating for the other residents and staff did not like it. Staff would laugh at me and treat me like an animal. They were treating me like a dog and making me stay in my room like I was in a prison around there (the facility). When I would say something back to the staff, I was told that staff were quitting because of me and that they would have to discharge me. I had put in an appeal and the facility did not even allow me to meet for the appeal. They decided to hurry up and do an emergency discharge right before the appeal (1-30-24) because their reasoning was staff were quitting because of me. I was forced to leave by the facility calling the police and intimidating me with the police. I had to go to the (homeless shelter). The (homeless shelter) was unable to accommodate my wheelchair to enter the building, I am sleeping on a floor which has caused me to be in excruciating pain due to my lower back. I have had major chest pains, and I am a nervous wreck. I am angry and I am scared I will not find anywhere to live or have transportation to make it to any doctor's appointments. I miss the staff at the facility that treated me good."

On 2-2-24 at 10:30 AM V14 (Social Service

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Director) stated, "I did not know PASRR level II's existed. All residents with PASRR level II recommendations have not had care plans developed with those recommendations."

On 2-2-24 at 11:15 AM V33 (R2's POA/Power of Attorney) stated, "The facility admitted (R2) from the same facility that they just discharged (R2) back to on Wednesday. That facility was not able to manage (R2's) behaviors either. I did not want (R2) to go back to that same facility. I did not even get a chance to decide on whether I was okay for the facility to transfer (R2) to another facility. (R2) had major behaviors when living at that facility before. The facility left messages on my phone and did not get my permission before sending (R2) to another facility. I called the facility and was told they had already transferred (R2) back to the old facility again because (R2) was having behaviors that they facility could not manage. The facility knew (R2) had behaviors when they accepted (R2) that she had major behaviors. (R2's) behaviors is the reason why the prior facility transferred her to this facility. (V14Social Service Director) told me the facility transferred (R2) to another facility so that (R2) would have a clean medical record regarding (R2's) behaviors and that would allow (R2) to get closer to me eventually. (R2) has had increased behaviors and anxiety the last two days since being sent to the other facility, and (R2) has been blowing up my phone."

On 2-2-24 at 11:30 AM V14 (Social Service Director) stated, "I tried to call (V33) four times on 1-30-24 about the facility transferring (R2) to another facility. (V33) did not answer. The other facility was a safer place for (R2). (V33) called me back the next day on 1-31-24 and I let him know we transferred (R2) to the other facility.

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(V33) did not really like that (R2) was transferred to the facility that she had was at before." V14 stated she was not aware of any documentation in R2's record of the needs the facility could not provide to R2 or the interventions attempted to meet those needs prior to transferring R2 to another facility."

On 2-2-24 at 1:00 PM V54 (Business Office Manager/BOM) stated, "I am responsible to ensure any resident that has a "HIT" with a qualifying conviction on their background check, gets set up for fingerprinting. I follow our policy and guidelines to ensure every step is being taken and things are followed appropriately. Once a "HIT" is identified we will put that resident in a private room until all steps have been completed per policy and we receive an email from the state police that lists security measures and recommendations for an identified offender. The report usually states if the resident is at low, moderate, or high risk with recommendations." V54 acknowledge R11 is an identified offender and confirmed that the only paperwork she could locate was R11's background check. V54 stated she was not here when R11 admitted, but she is now conducting a facility wide audit to ensure correct resident offender status. V54 also confirmed R11 had a roommate (R10) while residing at the facility.

On 2-2-24 at 1:15 PM V18 (Corporate Regional Nurse) verified R11 is an identified offender. V18 stated the facility must have not set up R11 to have fingerprints done because (the facility) cannot find any documentation that R11 was ever set up for fingerprints.

On 2-2-24 at 3:34 PM V37 (CNA) stated, "I have worked at the facility for around six months. (R11)

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had very few behaviors when I first worked for him. Within the last couple months, I noticed his behaviors were increasing. I believe it was after the involuntary discharge was given to him. I never see (R11) get physical with residents. There was one time a resident was talking to herself and (R11) went up to her and started to be bossy, but that's about it. The facility did not train me or tell me behavioral interventions to deal with (R11's) behaviors besides getting the nurse. I never received any behavioral training. I was not taught any other behavior interventions to deal with (R11)."

On 2-6-24 at 2:00 PM V1 and V54 (BOM) both stated they were not aware that R37 was a high risk identified and needed a private room. V1 and V54 both stated R37 has had a roommate (R67) since admission on 12-4-23.

On 2-7-24 at 2:00 PM V16 (CNA Supervisor) verified she tracks the employee trainings and the employees have not received behavioral management training since last year.

The facility's Administrator's Job Description (undated) documents, "The administrator is responsible for managing, planning, organizing, staffing, directing, coordinating, reporting, budgeting, and the physical management of the facility, residents, and equipment in a way that the purpose of the facility shall be maintained in accordance with all established practices, policies, laws, and applicable State Regulations. The Administrator will manage and conduct the business of the facility in a manner that protects the facility licensed and certification at all times. The major goal of the Administrator is to provide an atmosphere in which residents may achieve their highest physical, mental, and social

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well-being. Responsibilities: 1. Operate the facility in compliance with all Federal and State rules and regulations. 2. Operate the facility in accordance with established policies and procedures. 5. Ensure that an adequate number of appropriately trained professional and auxiliary personnel are on duty at all times to meet the needs of the residents. Resident Rights: 2. Ensure that the resident's rights to fair and equitable treatment, self-determination, individuality, privacy, property, and civil rights, including the right to wage complaints are well established and maintained at all times. 5. Ensure that policies governing a timely notice for resident discharges and room, or roommate changes are strictly followed by all personnel. Administrative Functions: 2. Maintain written policies and procedures that govern the operation of the facility. 6. Ensure that all employees, residents, and visitors follow established policies and procedures. 14. Ensure that appropriate policies and procedures are followed when conducting background checks and when providing information to the Nurse Aide Registry.

The facility's Identified Offender Policy and Procedure documents, "Policy Statement: It is the policy of this facility to establish a resident sensitive and resident secure environment. In accordance with the provisions of the Nursing Home Care Act, this facility shall check the criminal history background on any resident seeking admission to the facility in order to identify previous criminal convictions. It is the policy of (the facility) that no person will be admitted if they are sex offenders. Responsibility: Administrator or a person designated by the Administrator. Identifying Offenders: 3. Conduct a Criminal History Background Check: Within 24 hours of admission, request a name-based

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requirement."

The Facility Assessment Policy (reviewed 10-23-23) documents the following: "Resident admission based on common diseases, conditions, physical and cognitive disabilities, or a combination of conditions that require complex medical care and condition management. The list below describes residents' that (the facility) accommodates for and regularly manages. Category: Psychiatric/Mood disorder- Psychosis, Hallucinations (auditory), delusions, mental disorders, MR (Mental Retardation) disorders, anxiety, schizoaffective disorder, bipolar disorder, PTSD (Post Traumatic Stress Disorder), behavior requiring interventions, suicidal ideations, and hx (history) of substance abuse. Evaluation of the overall number of facility (direct care) staff members to ensure a sufficient number of qualified staff is determined based on the number of residents requiring skilled services. (The facility) acuity level to assist in identifying the intensity of care and services needed to provide and meet resident care needs: Special Treatments and Conditions- Behavioral Health Needs- 123 average number of residents."

The Illinois Department of Public Health (IDPH) Identified Offenders Program Criminal History Analysis Security Recommendation Report (undated) documents, "High Risk-The resident requires a single room in close proximity to the nursing station to permit ongoing visual monitoring. The level of observation should be sufficient for early detection of behavioral changes. Regular assessment is necessary to determine whether closer monitoring or more frequent individual contact is indicated. Moderate Risk-The resident requires closer supervision and more frequent observation than standard or

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S9999	Continued From page 70 routine for most residents in an open facility. Regular monitoring should be attentive to behavioral changes that may signal a need for closer observation or sustained visual monitoring on a time-limited basis. Periodic assessments should ascertain whether the level of supervision is sufficient. Low Risk-the resident is subject to standard requirements for supervision in an open facility. Behavioral changes suggesting a need for closer observation should be noted and responded to according to standard facility procedures." "A"	S9999		