STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001531	A. BUILDING: _____ B. WING _____	C 06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNT VERNON HEALTH CARE CENTER	#5 DOCTORS PARK MOUNT VERNON, IL 62864

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Facility Reported incident of 05/17/24/IL174440	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.3240e) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care 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.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S9999	Continued From page 1	S9999		

Section 300.3240 Abuse and Neglect

e) When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that another resident of the long-term care facility is the perpetrator of the abuse, that resident's condition shall be immediately evaluated to determine the most suitable therapy and placement for the resident, considering the safety of that resident as well as the safety of other residents and employees of the facility. (Section 3-612 of the Act)

These Requirements are not met as evidenced by:

Based on interview, observation, and record review the facility failed to ensure residents were free from abuse for 4 of 5 (R2, R3, R4, and R5) residents reviewed for resident-to-resident abuse incidents in the sample of 8. This failure resulted in R2 sustaining a fractured rib, R4 sustaining a skin tear to left arm, and R5 sustaining discoloration to left cheek bone due to peer to peer physical altercations with R1.

Findings Include:

1. R2's undated New Admission Information sheet documents R2 was admitted to the facility on 3/8/24 with diagnoses that include dementia.

The facility final follow-up report dated 5/23/24 documents, "This report serves as the final follow up report to the initial report filed on 05/17/24 regarding an allegation of physical contact between (R1) and (R2) ....R2 ....diagnoses include dementia ....His current BIMS (Brief Interview for Mental Status) score is 13 (this

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001531	A. BUILDING: _____ B. WING _____	C 06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNT VERNON HEALTH CARE CENTER	#5 DOCTORS PARK MOUNT VERNON, IL 62864

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S9999	Continued From page 2	S9999		

indicates he is cognitively intact) ....On 5/17/24 @ (at) approximately 1:35pm, it was alleged that physical contact occurred between (R2) and (R1) ....Investigation initiated immediately per protocol. Residents were separated and assessed .... At the time of the alleged contact, V20 (previous Administrator), V2 (Director of Nursing/DON), V3 (Assistant Director of Nursing/ADON) and V15 (Social Services Director/SSD) were in a meeting in the Administrator's office. A noise was heard on the north hallway. Upon entering the hallway R2 was observed by V20 lying in the doorway of his room on his right side. He was noted to be alert and talking normally with normal confusion. V2 noted R2 had a purple area to his right outer and inner elbow. When asked what hurts, he stated, "right here" indicating his right ribcage area. There was no swelling noted to the area when assessed by V3 but noted slight redness to the right torso. Order was obtained for x-ray to right arm and ribs. At approximately 5:00 PM, mobile x-ray had not arrived to complete x-rays and R2 was complaining of worsening pain. He was sent to local ER (Emergency Room) for further evaluation and treatment. X-ray report received from local hospital indicated acute fracture of the right lateral rib 7. No other injuries noted. He has returned to baseline function. R1 was observed standing very close to R2 when employees first observed R2. R1 was redirected away from the area by V17 (Certified Nursing Assistant/CNA). As he was walking away, R2 stated, "he got me." R1 was noted to have no redness, discolorations, or complaints upon assessment by V6 (Registered Nurse/RN). During interview R1 reported that R2 was in his room. When interviewed again by V20, R1 stated that he didn't know why "that man was in my room." He was unable to verbalize any other information about the alleged contact. When R2 was interviewed by

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001531	A. BUILDING: _____ B. WING _____	C 06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNT VERNON HEALTH CARE CENTER	#5 DOCTORS PARK MOUNT VERNON, IL 62864

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 3	S9999		

this administrator, he said that he came into his room and saw R1 in the bed. He didn't want R1 in his room and told him to leave. R1 told R2 to leave him alone and walked toward the doorway. When asked if R1 put his hands on him, R2 did not answer directly. He stated, "He got me out. He got me." Neither resident was able to recall if any physical contact occurred between them. In conclusion, it was determined that R1 entered R2's room believing it was his due to his cognitive state. R2 became upset and attempted to escort R1 from the room when R2 fell. The QA committee met and placed a visual cue on R2's door to assist other residents from entering his room. R1 remains on 15-minute visuals and staff will continue to redirect him from entering other resident rooms. There has not been further contact between R1 and R2 and both residents have resumed their daily activities. Both residents' care plans have been updated to reflect their current status."

A handwritten untitled statement by V17 (CNA) dated 05/17/24 at approximately 1:40 PM documents: I, (V17), CNA was at the nurses station charting. I looked at the monitor and noticed resident (R1) exiting his room and going to the bathroom on front east hall. A few moments later he entered resident (R2's) room. Again, looking at the monitor I saw resident (R2) falling in the corridor and resident (R1) looking out the doorway of the room. I ran to the front hall where the incident occurred to attend to the situation. All needed personnel and others also assisted as well." An additional noted added by V20 (previous Administrator) on this statement notes: "V17 redirected R1 away from the room, while V20, V2, and V3 and nurse (V6) assisted R2."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001531	A. BUILDING: _____ B. WING _____	C 06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNT VERNON HEALTH CARE CENTER	#5 DOCTORS PARK MOUNT VERNON, IL 62864

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S9999	Continued From page 4	S9999		

A handwritten untitled statement by V3 (ADON) documents: "On 05/17/24 at 1330 (1:30 PM) this nurse (V3) noted resident (R2) to be lying on R (right) side outside his bedroom door in the hallway. Peer (R1) standing inside his doorway. Resident appears to be upset and states that man got him out of his room. Bruises noted to R lower forearm, below R elbow, and a little redness noted to R torso. Resident c/o (complains of) pain to his R rib cage.

A handwritten untitled statement by V2 (DON) dated 05/17/24 at 1340 (1:40 PM) documents: "I (V2) was in a meeting in the administrator's office when we heard a noise in the north hallway of the Dementia unit. On entering the hallway, I saw resident (R2) lying in the doorway of (room number). He was reclined back holding his head up off the floor. He seemed to be lying more on the right side. He was alert, talking, but forgetful as per usual status. Skin assessment showed a purple area starting below his R outer elbow and another on his R inner arm below the elbow. When asked by another nurse what hurt he replied "right here" touching his R ribs. (No) marks noted there. (No) marks on his head. Resident (R1) had been standing in very close proximity to resident (R2) when I first observed them. Staff redirected (R1) away from the area. Resident (R2) commented "He got me."

R2's local area hospital records dated 05/17/24 document: Impression: Acute appearing fracture of the right lateral rib 7.

R2's Nurse's Notes dated 05/20/24 at 2400 (12:00 AM) documents: Resident (R2) awake complaints of right side pain, rib fracture area.

On 06/17/24 at 11:56 AM, V3 (ADON) stated R1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001531	A. BUILDING: _____ B. WING _____	C 06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNT VERNON HEALTH CARE CENTER	#5 DOCTORS PARK MOUNT VERNON, IL 62864

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 5	S9999		

went to the bathroom and when he came out, he went into the wrong room. V3 stated R1 laid down in R2's bed and when R2 came back into his room, he was agitated R1 was in his bed.

On 06/17/24 at 2:30 PM, V6 (RN) stated they did not actually see the incident between R1 and R2, they looked up at the monitor and saw R2 on the floor, halfway in the room, and halfway in the hallway. They went down to R2's room and R1 was in R2's room. R1 could have been sleeping in his bed and that would have upset R2. V6 stated there were no staff there to witness it, the first they saw on the monitor was R2 on the floor.

On 06/17/24 at 9:40 AM, V5 (RN) stated, the general procedure for a peer-to-peer incident would be to keep them apart but other than that she doesn't know. With R1 and R2 they both wander and are both ambulatory. V5 stated she would redirect them back to their own rooms. V5 stated, R1 and R2's rooms are next to each other's.

On 06/20/24 at 9:51 AM, V15 (SSD) stated with R1 they have had his medications re-evaluated. V15 stated R1 usually doesn't just act out; someone gets in his face. V15 stated the incident with R1 and R2, R1 was in R2's room, R1 thought it was his room and R2 said he wouldn't leave. V15 stated for R1's behaviors of aggression and agitation they have done medications, he doesn't stay focused, so if they see it, they redirect him with coffee or something.

On 06/20/24 at 9:47 AM, when asked if the intervention was to "redirect to a different area location if restless," for R1's peer to peer with R2, V2 (DON) stated, "yes." V2 stated they put a stop sign on R2's doorway. When V2 was told the stop

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001531	A. BUILDING: _____ B. WING _____	C 06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNT VERNON HEALTH CARE CENTER	#5 DOCTORS PARK MOUNT VERNON, IL 62864

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 6	S9999		

sign had not been across R2's doorway at any observed time on 6/17/24 and was no longer hanging on the wall on 6/20/24 at 8:30 AM to current time, V2 stated he probably didn't know how to put it back across his door, but staff should have put it across the doorway. V2 stated she didn't know why the sign was gone.

2. R4's undated Face Sheet documents an admission date of 06/09/23 with diagnoses including dementia without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety and anxiety disorder. R4's MDS (Minimum Data Set) dated 03/15/24 documents a BIMS score of 03, indicating severe cognitive impairment.

The facility final follow-up report dated 2/22/24 documents, "This serves as the final follow up report to the initial report sent 02/18/2024 regarding an alleged incident of peer to peer contact involving (R4) and (R1) ...On 02/18/24 at approximately 3:35 PM, it was reported to V20 by V6 (RN) that an alleged peer to peer incident had occurred with R4 and R1. Residents (R4 and R1) were immediately separated and assessed... During investigation, V6 (RN) reported that R4 approached the nurses' station and stated, "he attacked me." R4 indicated R1. R4 was noted to have a skin tear to left lower arm, approximately 3 cm (centimeters) x 4 cm. Area was cleansed and steri-strips applied with dry dressing to cover. R4 reported to V6 that R1 called her "a whore" then "attacked her." This allegedly occurred in the dining room and was not witnessed by staff. V6 reported there was no blood or other substance noted to R1's fingers or hands during the assessment. V6 reported that R4 was calm when she reported the incident to her but when she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001531	A. BUILDING: _____ B. WING _____	C 06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNT VERNON HEALTH CARE CENTER	#5 DOCTORS PARK MOUNT VERNON, IL 62864

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 7	S9999		

spoke to her husband, she became agitated and made crying sounds. She was upset that her husband wasn't here with her and wanted to see him. When the call ended, R4 returned to her previous calm state. CNAs working the dementia unit at the time of the alleged incident were assisting other residents and did not witness any event involving residents. When V20 spoke with R4, she stated that she was sitting in the dining room in the chair she usually sits in talking with another female resident. R1 was at another table then came over to where R4 was sitting. She reported that he called her a whore then shoved his chair against her left arm that was draped over the arm of the chair. This caused the skin tear to her arm. She then went to the nurse and had treatment applied. Another resident sitting in the dining room with R4 reported during interview with V20 that "the man did call her a whore and got up from the chair." V2 (Director of Nursing) stated during interview that R4 reported to her on 02/19/24 that "loverboy" (referring to R1) was mad and pushed the chair he had been sitting in. His chair hit her left arm that was draped over the arm of the chair she was sitting in and caused the skin tear. When V20 spoke with R1, he was unable to recall the incident but stated that "everybody here is ok." In conclusion, the facility can substantiate that an injury occurred during an interaction between R4 and R1. However, the allegation of being attacked is not substantiated. IDT met and reviewed. Care plans updated to reflect current status. Both residents remain at baseline and have had no further incidents at this time. V15 (Social Service Director) will follow up with R4 to discuss any safety concerns weekly x 3 weeks. R1 is on 15-minute visual checks."

A written statement from V6 (RN) documents in part, V6 was informed of an injury to R4's arm.

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	IL6001531	A. BUILDING: _____ B. WING _____	C 06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNT VERNON HEALTH CARE CENTER	#5 DOCTORS PARK MOUNT VERNON, IL 62864

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 8	S9999		

R4 stated, "he attacked me." The skin tear was 3 cm x 4 cm with irregular edges. R4 was calm with no complaints of pain or discomfort. R4 spoke with her husband and was very anxious and complained that he wasn't with her, and she needed to see him. Staff closely monitored both residents. R4 reported R1 was calling other resident's whores. Investigation started and V20 informed.

R1's nurse's notes dated 02/19/23 at 8:30 AM document a peer to peer reported to his nurse (V6), this nurse (V6) will investigate incident. R1's nurse's notes dated late entry 02/18/23 at 3:30 PM, incident was unwitnessed though resident was in dining room at the time of the incident. R1's nurse's notes dated 02/19/24 at 12:37 PM states: Monitoring regarding the peer to peer. Zero behaviors noted. Resident (R1) pleasant with staff and peers...

On 06/25/24 at 2:10 PM, V21 (CNA) stated she does not remember the incident (with R4) in February exactly but R1 will cuss you out and call you names if he is in a mood and doesn't get what he wants, so she has heard him call people names, just does not remember the incident in February.

3. R5's undated Face sheet documents an admission date of 05/17/23 with a diagnosis of dementia with agitation. R5's MDS dated 05/29/24 documents no BIMS was completed due to resident is rarely/never understood.

The facility final follow-up report dated 11/24/23 documents, "This letter is to serve as the final follow up report to the incident of alleged resident to resident contact sent on 11/19/23 involving (R5) and (R1) ....On 11/19/23, this administrator

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001531	A. BUILDING: _____ B. WING _____	C 06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNT VERNON HEALTH CARE CENTER	#5 DOCTORS PARK MOUNT VERNON, IL 62864

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 9	S9999		

(V20) received a report of alleged resident to resident contact from nurse (Name of V7 - Licensed Practical Nurse/LPN) at approximately 7:40 AM. (Name of R5) and (Name of R1) were heard by staff yelling at each other. They were immediately separated and assessed with no injuries noted ....CNAs (V12) and (V19) were assisting other residents when they heard R1 and R5 yelling. When the CNAs arrived at the door to R5's room, R1 was standing outside the doorway in the hall. R5 was in the doorway. R1 stated to V12 that "he hit me first." She (V12) then assisted R1 to his room while V19 attended to R5. V19 reported incident to nurse (V7/LPN). Initial assessment indicated no obvious injury. However, approximately 15 minutes later, V7 observed an area to the left cheekbone of R5 that was discolored. His skin to the area intact and without swelling, he made no complaints of pain or discomfort. When this administrator (V20) attempted to interview R5 about the incident, he was unable to recall that anything happened and that he was "doing ok." In speaking with R1, he did not recall being upset or that anything had taken place. Staff reported that by the time residents were finished with the morning meal; neither R5 nor R1 appeared agitated or upset. Neither resident exhibited any further aggressive behaviors ..."

V19's (CNA) handwritten statement regarding the 11/19/23 incident between R1 and R5 documented: approximately at 7:30 AM, V19 was assisting R6 and heard yelling, she walked to the front hall and saw R5 and R1 yelling in the bedroom. Both residents stated the other had hit them. V12 (CNA) assisted R1 to his room and V19 assisted R5 in his room. V19 reported incident to V7 (LPN). R5 was unable to recall who interacted with him minutes later.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001531	A. BUILDING: _____ B. WING _____	C 06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNT VERNON HEALTH CARE CENTER	#5 DOCTORS PARK MOUNT VERNON, IL 62864

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 10	S9999		

V12's (CNA) handwritten statement regarding the 11/19/23 incident documented V12 was assisting R7 in her bedroom and heard yelling. She walked with V19 to front east hall. R5 was standing in the doorway and said R1 hit him. R1 was standing away from R5 with closed fist. V12 took R1 back to his room to assist him. R1 stated, "he hit me first." R1 did not exhibit further aggression toward staff or residents.

V7's (LPN) handwritten statement regarding the 11/19/23 incident documented V19 (CNA) reported at 7:30 AM that an incident occurred. Residents (R1 and R5) were in each of their rooms. R1 has no visible injuries, R5 initially had nothing visible, approximately 15 minutes later V7 noted a quarter sized discoloration to left cheekbone. R5's skin is intact and there is no swelling. V7 notified medical doctor, power of attorney, and V20 (previous Administrator). R1 and R5 are both on 15 minute checks.

4. a) R3's Face sheet documents an admission date of 11/14/2019 with a diagnosis of dementia with psychotic disturbance. R3's MDS dated 05/02/24 documents a BIMS score of 07, indicating severe impairment.

The facility final follow-up report dated 3/25/24 regarding a resident-to-resident incident investigation involving R1 and R3 documents in part: On 03/21/24 at approximately 1:25 AM, V20 (Previous Administrator) received report that an alleged peer to peer incident involving physical contact occurred at approximately 7:30 PM on 03/20/24. Investigation initiated immediately per protocol. An investigation was conducted, and it was determined that the alleged incident was witnessed by V4 (RN). When asked if she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001531	A. BUILDING: _____ B. WING _____	C 06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNT VERNON HEALTH CARE CENTER	#5 DOCTORS PARK MOUNT VERNON, IL 62864

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 11	S9999		

witnessed physical contact between R1 and R3, she stated "no." There were no injuries observed to either R1 or R3. Neither resident could state what happened when asked by V20, V2 (DON) or V3 (ADON). It was noted during investigation that R3 does often verbally antagonize R1 about "taking my keys" and "stealing my car." In conclusion, the allegation of peer-to-peer physical contact could not be substantiated. Both R3 and R1 remain at baseline. Since R3 attempts to antagonize R1 she had a medication review completed on this day with a new medication ordered. She will be monitored for any side effects. She will also be 1:1 supervision when in TV area and redirected to activities of interest. R1 will continue to be monitored for any side effects of a recent medication change.

4. b) The facility final follow-up report dated 3/14/24 regarding a resident-to-resident incident investigation involving R1 and R3 documents in part: On 03/09/24 it was reported to V20 (Previous Administrator) that R3 and R1 were involved in an alleged peer to peer physical interaction at approximately 2:00 PM. Residents were immediately separated and assessed. During this investigation, the nurse V13 (LPN) reported that the residents were in the TV lounge when yelling was heard. When V14 (CNA) arrived to the area, she observed R1 standing where R3 was getting up from the floor. She assisted R3 in standing up so V13 could assess her. She was noted to have a scrape to her left knee with no other injuries observed. R1 was assisted to his room by V14 without any issues. R3 stated, R1 pushed her. R1 stated "everything's ok" when asked what happened. When asked again by V20 what happened on a later day, R3 stated that she was ok, but that man yelled at me. R1 stated, "everything's ok" and was unable to recall any

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001531	A. BUILDING: _____ B. WING _____	C 06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNT VERNON HEALTH CARE CENTER	#5 DOCTORS PARK MOUNT VERNON, IL 62864

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 12	S9999		

other details. The alleged incident was not witnessed by staff and there were no other residents in the area at the time of the incident. In conclusion, the facility was unable to substantiate the allegation of peer-to-peer contact between R3 and R1. The QA (Quality Assurance) team met and both residents' care plans have been updated to reflect their current status. R1 was reviewed by psychiatry and had a medication adjustment. R3 was placed on 15-minute visual checks. Both R3 and R1 remain at baseline.

A written statement by V14 (CNA) states: "At the time of 1:58 PM, I was walking down back hall when I heard yelling at the TV area. When I got to the TV area R3 was getting off the ground and R1 was standing over her. I helped her up and took R1 to his room."

On 06/24/24 at approximately 3:35 PM, V1 (Administrator) stated she could not find any fall/incident investigation for R3 for 03/09/24, however V2 (DON) gave her R3's "Care Need Notice" dated 03/21/24. V1 stated R1 and R3 did also have an incident on 03/21/24 that was investigated as a peer to peer. V1 stated, she does not have any other documentation for the 03/09/24 incident.

4. c) The facility final follow-up report dated 1/24/24 regarding a resident-to-resident incident investigation involving R1 and R3 documents in part: On 01/19/2024 at approximately 6:00 PM, nurse (V5 - Registered Nurse/RN) reported to this administrator (V20/Previous Administrator) that an incident of alleged physical contact occurred involving R3 and R1. The residents (R3 and R1) were immediately separated and assessed for injuries. Investigation initiated per protocol. During investigation, V20 attempted to speak with R3

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S9999	Continued From page 13	S9999		

about the incident immediately following the alleged occurrence. R3 stated, "I don't know what got into him. I wasn't doing anything when he came over to me." When R1 was asked about what happened, he stated, "she wouldn't shut up." When interviewed about the incident, V5 (RN) stated that she witnessed physical contact between R3 and R1. She was in the common area where both R3 and R1 were watching TV. R3 was sitting on her wheeled walker seat in front of the couch. Another resident wanted to sit down but R3 was blocking the seat. R1 told R3 to move in a rude manner. R3 stated, "Don't tell me what to do." R1 then approached her and used an open hand to make contact with R3's left cheek. There was a slight pink discoloration noted that disappeared after the contact. Skin was not opened or further discolored. R3 placed her hands around both of R1's hands to push him away. This resulted in a slight skin tear to the top of both of his hands. TAO (triple antibiotic ointment) and bandage applied per order. No other injuries were noted. Neither resident made further complaints after the incident nor other negative behaviors occurred. No other staff witnessed the event as they were assisting other residents at that time. A female resident in the area stated "that man is mean" but was unable to verbalize further details during the interview.

The untitled document dated 01/19/24 documents the facility name, "resident/victim/perpetrator" R3/R1, and "initial incident description" at approximately 6:00 PM on this date, V5 (RN) notified this writer that an incident had occurred involving R3 and R1. Residents (R3 and R1) immediately separated and assessed for injuries. Investigation initiated per protocol. Resident (R3 and R1) remain at baseline.

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S9999	Continued From page 14	S9999		

On 06/17/24 at 11:12 AM V5 (RN) stated, she was the nurse working in January when R1 slapped R3. She does not remember who the other resident was that said R1 was mean.

R1's Face sheet documents an admission date of 04/21/23 and a diagnosis of dementia with agitation.

R1's MDS (Minimum Data Set) with Assessment Reference Date (ARD) of 4/29/24 documents a BIMS (Brief Interview of Mental Status) score of 02, indicating R1 has severe cognitive impairment. MDS Section E - "Behavior" has Delusions checked and has physical and verbal behavioral symptoms coded as 0, indicating R1 did not exhibit these behaviors in the 7 day look back period. This same MDS documents R1 wandered daily but documents the wandering did not intrude on the privacy or activity of others.

R1's Social Service progress notes dated 05/05/24 documents R1 continues to ambulate up and down halls daily, communicates but doesn't always make sense, loses his train of through, can't remember where his room is. This same note documents R1 needs minimal assist with activities of daily living and feeds himself.

On 06/20/24 at 9:05 AM, V7 (LPN) stated if they see R1 agitated they will call psychiatric services in. V7 stated they redirect him with coffee or a snack. V7 stated R1 doesn't really do the busy boards, but he will sit up by the nurse's station and chat. V7 stated R1 has been pretty good this month but they watch him on the days he is more confused. V7 stated R1 will have behaviors later in the day, but she isn't working then.

On 06/17/24 at 12:50 PM, R1 was observed

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S9999	Continued From page 15	S9999		

wandering into R8's room.
On 06/17/24 at 12:55 PM, R1 was observed wandering up and down the hallways.
On 06/25/24 at approximately 2:10 PM, R1 was observed wandering up and down the hallways.

R1's current Care Plan documents category area of "Behavior" and "Resident known to wander and may seek to leave the home ...Related Dx (diagnosis of dementia with aggression)" with a start date of 5/29/23." R1's Care Plan does not mention R1's history of aggressive behaviors towards peers. There are no progressive person-centered interventions listed to address R1's altercations/aggressive behaviors towards peers which are at times related to his wandering behaviors. There were no person-centered interventions listed on R1's Care Plan for aggressive behaviors and all interventions listed for this category appear to be generated from a program, not resident centered and document dates of 05/29/2023.
On the back of a piece of the paper Care Plan, there is a documented running list of handwritten dates and notes that are not related to any particular category in R1's Care Plan. Some of these handwritten dates and notes document the following: 11/19/23: 15 minute visuals x 72 hrs (hours), 3/11/24: resident will be redirected by staff whenever he makes allegations towards other residents and 04/17/24: 15 minute visual monitoring, redirect to a less busy area, and redirect away from other resident rooms. A "Care Need Notice" document dated 05/17/24 documents under "what to do" 1) monitor with 15 minute visual checks 2) redirect to a different area location if restless, redirect away from other resident rooms.

On 06/17/24 at 2:05 PM, V18 (Care Plan

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S9999	Continued From page 16	S9999		

Coordinator/CPC) stated R1 has had a few behaviors since she has been here (she has been here approximately 9 months, but she only works two days a week), personal space has been an issue. He wanders and has dementia and confusion. She does not know about the intervention for him on 04/17/24 to redirect to a less busy area and to redirect away from other resident rooms, or the event that happened to put the intervention in place, she did not put that intervention in place. V18 stated, if she is not working that day, other staff will put interventions in place, she will try to keep up with them the next day she works. She does not see an intervention for the incident on R1's care plan for the 05/17/24 incident.

On 06/20/24 at 10:05 AM, V3 (ADON) stated she sees where the care plan states to redirect on 03/11 and 04/17 but she is not sure what they did for the other incidents before.

On 06/27/24 at 12:43 PM, V22 (Regional Reimbursement Specialist/LPN) stated the care plan interventions for R1 are program populated and should have been personalized, or personalized interventions also added, she will need to re-educate on that.

The Abuse Prevention Program dated 11/28/2016 documents: Dementia management and resident abuse preventions; including, how to assess, prevent and manage aggressive, violent and/or catastrophic reactions of residents in a way that protects both residents and staff.
(B)