STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145837	A. Building B. Wing	05/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pittsfield Manor	610 Lowry Street Pittsfield, IL 62363

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40650 Based on observation, interview, and record review, the facility failed to supervise and prevent an altercation for 2 of 2 (R3, R4) residents, reviewed for incidents and accidents in a sample of 5. This failure resulted in R4 being sent to the local emergency department after an altercation with R3 and sustaining facial contusion, contusion of both forearms and contusion to her right shoulder. Finding includes: R3's Minimum Data Set, dated dated [DATE], documented R3 was unable to complete the questions to gauge his cognition. It continued to document he was severely impaired for decision making, Physical behavioral symptoms directed towards other that had been occurring for 1 to 3 days and that he also had the ability to put others at significant risk for physical injury. R3's Face Sheet, undated, documented diagnoses of Dementia with agitation, Dementia with Anxiety and Blindness Right and Left eye. R3's Care Plan, dated 8/8/2023, documented, When (R3) is displaying s/s of behaviors offer to call his wife (V16, R3's wife). It continues, If (R3) displays behaviors during cares, allow him space and attempt task at a later time. R4's MDS, dated [DATE], documented R4's cognition was severely impaired. R4's Face Sheet, undated, documented a diagnosis of Dementia without behavioral, psychotic mood or anxiety disturbance. R3's Progress notes, dated 04/03/2024 at 1:00 PM, documented, [Recorded as Late Entry on 04/04/2024 11:04 AM] Resident was very confused and agitated with staff, Resident was yelling, help call the police, and was exit seeking. Resident did become combative with staff, and bit this nurse's arm, but did not break the skin. Resident was redirected, and his wife was called for a distraction. R3's Progress notes, dated 04/03/2024 at 2:19 PM, documented, Resident was increasingly agitated, with minimal success in redirecting with multiple different approaches attempted. His wife came to facility and talked with him to calm him. Resident setting in his room with his wife listening to a ballgame. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R3's Progress notes, dated 04/04/2024 at 09:23 AM, documented, (Resident) continues to have behaviors. (Resident) was assisted down to ride the exercise bike with therapy ad he refused to stand up and participate. Staff unable to redirect and had to bring (Resident) back to his room and assisted into recliner. Continues on rexulti medication change. R3's Progress notes, dated 04/06/2024 at 3:01 PM, documented, Resident was verbally aggressive this afternoon for a short period and was redirected with some effort. R3's Progress notes, dated 04/12/2024 at 2:22 PM, documented, Resident having verbal and physical behaviors towards staff. Stating he was going to get his hammer and hit this nurse and other staff. Redirected to recliner in room and resident continued to attempt to stand up and yell and hit staff. (as needed) Ativan given and able to redirect resident back into recliner and rest at this time. R3's Progress notes, dated 04/12/2024 at 10:56 PM, documented, (Resident) has extreme outburst with verbal and physical behaviors. Attempted to give prn Ativan, and (resident) spit it at nurse. (Continued) to attempt to de-escalate (resident) with no effect. CNA holding (resident) arms, as he was attempting to hit other (resident). Called (resident) wife/POA (Power of Attorney) and she came to facility with her daughter and finally got (resident). to lay down and rest. No further behaviors reported this (hour of sleep). MD (Medical Director) here this pm to give injection in rt knee. Tolerated well (without complaints). R3's Progress notes, dated 04/25/2024 at 10:43 PM, documented, Resident very aggressive with staff, kicking out and grabbing staff. Resident yells shut up and leave me alone when asked if we can help. Resident rolling in (wheelchair) at this time, one on one with staff. R3's Progress notes, dated 04/26/2024 at 11:38 AM, documented, (Resident) continues to have agitation and behaviors towards staff. He yells out at staff and does not want anyone touching him he states. He is having hallucinations that he is on the battlefield and people are trying to kill him. Staff able to redirect and resident currently resting in bed at this time. R3's Progress notes, dated 04/28/2024 06:53 AM, documented, Resident observed throwing drawers in resident room, physical and verbal behaviors towards staff as staff were attempting to redirect resident. CNA's notified nurses. Nurses attempted to redirect resident as well. Resident continued with physical behaviors which made resident very unsteady causing nurses to lower resident to floor for safety precautions. Resident continued to scream and yell out and continued with physical behaviors. Nursing staff notified MD on the phone and gave orders to administer 1 time dose of IM (Intramuscular) 2MG (miligram) dose of Ativan. POA contacted and made aware of behaviors and orders from MD for one time order of im Ativan. Verbal consent given from POA at this time. MD states he is sending script to pull from stat safe. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R3's Progress notes, dated 04/29/2024 at 10:15 PM, CNA reported that she heard a noise. Upon arriving at a female Resident's room she turned on the light and observed from the doorway this Resident was standing beside female Resident's bed and CNA observed a lamp in his right hand. Before she could get to Resident he hit the female Resident in the right side of the head with the lamp. Resident had noted to have ahold of the lamp shade that was still attached to the lamp and started tearing up the lamp shade. CNA reported that Resident called the lamp a horse. While attempting to redirect Resident from the area he reached for a plastic cup and hit female Resident in the head then attempted to hit CNA with lamp. Resident then was able to remove light bulb and threw it on the other side of the bed causing it break on the floor. Second CNA made the nurse aware. Resident redirected out of the room to his room. This nurse observed Resident attempting to ambulate unassisted and he lost his balance, when this writer attempted to assist Resident he became combative. With assist of CNA, Resident redirected to his recliner. Resident continued to talk about a horse to staff.in his room with no noted behaviors. He continued to talk about the horse as he was leaving with EMTs (Emergency Medical Technicians) Policeman present. The facility's Abuse Final for R3, dated 5/3/24, documented, .Interventions in place to ensure increased supervision of hall. Incident was behaviorally related due to the medication change and resident mental status. Will continue to monitor resident and redirect from behaviors. Staff in serviced on making sure that they are stationing themselves centrally on the hall to ensure resident safety. R4's Progress note, dated 04/28/2024 at 11:21 PM, documented, It was reported to this nurse that res was lying in bed sleeping CNAs heard a loud noise and CNAs ran to check on resident, a male resident was in her room and had hit res in the head with a lamp and then a cup, Res very upset very agitated, c/o rt eye pain, when this nurse assessed res Pupil active, no discoloration to eye res said she had vision but blurry, res had no bumps or lacerations to head, res was sent out to (local Hospital) for evaluation per (Emergency Medical Services). R4's Progress note, dated 04/29/2024 at 01:31 AM, (Resident) returned from (Local Hospital) with contusion to left forearm/right forearm/right shoulder strain and slightly red facial contusion near (right) eye, Right shoulder and forearm negative negative of fracture and CT (CAT scan) of face with contrast results negative of fractures. R4's Local Hospital Record, dated 4/28/24, documented, History of chief complaint: Patient struck about the head with a lamp and fist by male resident of the Nursing home. Patient complains of bilateral forearm pain and right shoulder pain. She suffers from dementia. It continues, Impression: #1 facial contusion, contusion of both forearms, contusion right shoulder. On 5/10/2024 at 5:19 PM, R3 was sitting at the table calmly waiting for dinner. R4 was standing at the big picture window watching a squirrel eat birdseed. On 5/20/2024 at 11:15 AM, R3 was sitting in his bedside chair and his call light was within reach. R3 was taking his shoes and socks off. There were no activities being performed, during this investigation, in the memory unit. There was 1 Certified Nurse Assistant (CNA) in the dining area with a few residents present. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 5/20/24 at 1:15 PM, V13, Certified Nurse Assistant, (CNA), stated on/around 4/28/24 around 11:00 PM, everything was going fine. He continued to state he and the other CNA had just walked up and down the hallway and R3 was in his bed. He continued to state he went to the nurse's station to get report, was there about 5 minutes and they heard a loud noise. V13 and V15, CNA, ran to R4's room and when they entered, V13 saw R3 with a lamp in his hand. The other CNA, (V15), told him to go get the nurse and he did. He also stated he did not see R3 hit R4. When asked if he was made aware R3 had behaviors earlier that day, he said he was made aware. When V13 was asked about if R3 had any special interventions for behaviors, he stated there are interventions on the care plan. On 5/20/24 at 2:35 PM, V15, CNA, stated she just got to the Memory Care Unit and was getting report when her and V13, CNA, heard a loud noise. They ran to R4's room, turned on the light, and saw R3 swinging the lamp. She was able to get the lamp from the resident, and at the same time, R3 grabbed R4's cup and hit her in the head with it. V15 continued to state R3 thought it was a horse. V15 also stated that doesn't usually work in the Memory care unit and was unaware of R3's increased behavior issues. On 5/20/24 at 2:20 PM, V14, Licensed Practical Nurse (LPN), stated when she came to the nursing home, the incident with R3 and R4 just happened. V14 assessed both and sent both residents to the hospital. She did not witness the incident. V14 also stated R3 has had increased behaviors for the past month, and they were changing his medication. She continued to state they redirect him, talk to him, but since he is blind, he really doesn't watch tv. She also stated she does not recall if she was told he was having behaviors earlier that day, and he was really a sweet person. V14 continued to state his dementia was advancing, and with his blindness it has gotten worse, and he was very sensitive to loud noises. On 5/10/24 at 4:03 PM, V4, CNA, stated, I was working on the day shift, and he (R3) was fine. Nothing about him was out of the ordinary. He does have bad vision. He can only see shadows. On 5/10/24 at 3:30 PM, V2, Director of Nurses (DON), stated, (R3) has a BIMS (Brief Interview of Mental Status) of 1. He lives on the Memory Unit. He got a hold of a lamp in another resident's room (R4) and hit her over the head with it. She was not hurt, but both parties went to the ER (emergency room) to be checked out. A police report was filed. He has very poor vision. His family says that he is totally blind, but he can see shadows. When this happened, they were immediately separated. (V1) and I were notified. (R3) was in the middle of a med (medication) change. He was being taken off of Seroquel and had started Rexulti. When (R1) came back, he was placed on 1 to 1 supervision until the next morning. He really didn't understand, but he did know that he hurt someone. (R4) she didn't remember anything about it. The next morning, she thought she was in a golfing accident. Staff told me he thought he was trying to saddle his horse. The next morning, neither of them remembered. Doctors have been keeping a close eye on him and have changed his meds. He does have behaviors but nothing violent. He is doing much better now. This happened in the middle of shift change between evening and night shift. On 5/10/24 at 4:10 PM, V3, Memory Unit Director, stated, (R3) would have his moments when he would get agitated, but nothing threw up flags to us that he needed constant supervision. When he does get agitated, he is very easy to redirect. This happened during shift change, so both evening shift and night shift were present. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 5/20/2024 at 2:45 PM, V1, Administrator stated she has increased staff on the memory hall for extra supervision. On 5/21/2024 at 10:21 AM, V1, Administrator, stated they do not have a specific policy related to Dementia Care or Supervision of Residents.