| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145969 | A. Building<br>B. Wing | 11/27/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Aperion Care Forest Park | 8200 West Roosevelt Road<br>Forest Park, IL 60130 |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50036<br><br>Based on interview and record review, the facility failed to protect residents from resident to resident physical abuse. This failure affects four of four residents (R1, R2, R3 R4) reviewed for abuse. This failure resulted in R1 getting feces thrown in R1's eye and on R1's body. This physical abuse caused R1 to feel upset, disgusted, abused, and scared R4 would throw more and R4 would try to attack R1.<br><br>Findings include:<br><br>1.) R1 is an [AGE] year-old resident admitted to facility on 2/17/2024 with medical diagnoses including but not limited to: major depressive disorder, moderate protein-calorie malnutrition, adult failure to thrive and age-related osteoporosis.<br><br>R1 has a Brief Interview for Mental Status (BIMS) score of 9/15 dated 10/30/2024 which suggests moderate cognitive impairment.<br><br>Minimum data set (MDS) section GG dated 10/30/2024, R1 requires substantial/maximal assistance for shower/bathe self, upper body dressing, lower body dressing, putting on/taking off footwear and personal hygiene. R1 is dependent on staff for toileting hygiene. R1 needs partial/moderate assistance for oral hygiene. R1 needs supervision or touching assistance for eating.<br><br>R1 reported an allegation of abuse on 11/19/2024 that had allegedly happened on 11/17/2024 to the State Survey Agency.<br><br>On 11/25/2024, at 09:33 AM, R1 stated, regarding another resident throwing feces/urine at me this happened in R1's old room. R4 was my old roommate. They moved me after that. R4 uses a colostomy bag. Feces got in my eye. The facility did not send me to the doctor. My linens were all a mess, and I was hollering, and the nurse came to my room. The nurse V5 LPN (Licensed Practical Nurse) helped clean me up. The social worker came in and asked me what happened I am not sure if the other resident (R4) is still here. I did have eye drops put in my eyes after that which helped. I do not have any other problems other than my complaint.<br><br>On 11/25/2024, at 12:31 PM, R1 stated it made me feel awful and scared when R4 threw feces on me. We shared food and stuff before this. I feel safe to stay here now. I don't believe they will allow anyone to come in here and abuse me again.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | On 11/26/2024, at 11:05 AM, R1 stated I felt just terrible and awful when R4 threw feces at me. It felt disgusting to have feces all over me. It got in my eye and all over my body. I was scared that R4 might throw more or reach over and try to attack me. I called my son right after the nurse (V5) cleaned me up to tell him because I was so upset. My son got upset too. It felt like something was under my eyelid. That was an uneasy feeling.<br><br>On 11/25/2024, at 12:23 PM, surveyor asked R4 if she got in an altercation with R1 last week. R4 stated, I am a nice person I did not try to throw anything on R1 I have nervous hands. I am a nice person. R1 don't like me. I'm going to stay in this room. I like it here. I am a nice person; I didn't try to do that.<br><br>R1's Progress note dated 11/17/2024 documents: Late Entry:<br><br>Narrative: V5 informed by certified nursing assistant that resident roommate bodily fluids made contact with her. V5 immediately intervened, R1 sitting on the own separate bed, close curtains to make sure remain separation. Full head to toe body assessment made and no injuries noted. ADL care performed on R1. V5 remain with resident until certified nursing assistant came and took resident to shower room.<br><br>R4 progress note dated 11/18/2024 documents in part: Note Text: Resident's behavior/mood noted at times. Resident's behavior noted as was physically aggressive. Other resident specific behaviors not noted above: Bodily fluids making contact to roommate (R1)<br><br>Reportable initial transmission dated 11/25/2024 for this incident that occurred on 11/17/2024 reviewed.<br><br>On 11/27/2024, at 12:43 PM, V30 (CNA) stated, regarding the incident that involved R1 and R4 about a week ago, I went down the hall and when I got to that room R4 was upset about not eating her lunch as it ended up on the floor. Both R1 and R4 were arguing back and forth on how the lunch got on the floor. I went to get her a sandwich, cookies and potato chips. She was thankful for that and R1 and R4 were calm. I went to check on R1 and R4 about an hour later. R4 asked if I could help her empty her colostomy bag. R4 said, I can do it, but her hand was shaking really bad. I put two towels under her breast like R4 asked and R4 pushed the bowel movement out of her colostomy bag into the gradual container. I cleaned the gradual. R4 asked me for the gradual container back so she could empty colostomy later. Both residents were calm when I left the room. Later, I was passing down the hall with my dirty linen cart and R1 and R4's room light was on. R1 stated, R4 got bowel movement on me. I had already done rounds on that room. I went in the room to see what R1 needed and seen bowel movement on R1's arm. R4's gradual container to empty R4's colostomy was laying on R1's arm. R1 was starting to make a phone call. R1 was upset and I went and told the nurse.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | On 11/25/2024, at 1:34 PM V6 (Social Worker) stated, I was notified of the incident with R4 throwing feces at R1 on Monday when I returned. That incident happened on a Sunday from my understanding. I asked how the situation escalated. R1 and R4 had already been separated in different rooms. I interviewed each resident to see what went on. R4 did not have much to say except being upset that she could not discharge home. R4's mom can no longer care for her. R4 stated she had been under some stress over this and kind of reacted. R1 explained R4 was having an episode and R1 was asking if R4 was ok. R4 started calling R1 names and everything escalated from there. R1 said she got feces in her eye and mouth and R1 was screaming. The nurse (V5) and certified nursing assistant got her into the shower chair and went to clean her up and separated R1 and R4 immediately. I have been doing well being checks on R1 and R4 since that incident.<br><br>On 11/25/2024, at 09:56 AM, V5 Licensed Practical Nurse (LPN) stated I am aware of an incident of R4 throwing feces at R1. It happened last week Sunday (11/17/2024). R4 is still here and on this floor. When I came in that morning, I was informed by certified nursing assistant that R4 threw feces on R1. That happened before I got here. I went straight to that room. Both R1 and R4 were in their bed. I cleaned R1 up and stayed with her until certified nursing assistant came and got her up to go to shower. R1 had already notified her son. I did notify V3 (Director of Nursing). R1 said some feces splashed in her eye so I rinsed them out. V31 (Nurse Practitioner) came later in the week to see her. No new orders. R4 is now in a room by herself. That was the only time R4 ever did something like that.<br><br>On 11/26/24, at 11:27 AM, V3 Director of Nursing (DON) stated, regarding the situation with R1 and R4, I do recall this was on a Sunday (11/17/2024). The nurse sent me a message that R1 had feces on her. I asked what happened and R1 stated it came from R4 direction. The nurse would get assistance to clean her up. I asked how both residents were. Nurse stated, they were both ok. I told her to ask R4 if she knew how the feces got on R1. R4 initially said, I don't know. I did delegate to nurse to notify family and physicians. I don't recall hearing about R4's family. I do know the nurse got ahold of R1's son. I was made aware there were no injuries. When they cleaned up R1 the staff removed her from the room while we investigated what had happened. I was not made aware that R1 stated she got feces in her eye. I was made aware she had feces in her hair and on left shoulder. Monday morning comes and it is thoroughly investigated, and administration got involved. Monday it was found out that R4 threw feces at R1. R4 did tell a staff member on Monday that her cousins made her do it. R4's cousins were not in the facility at this time. This would be considered abuse. V1 (Administrator) is the abuse coordinator. I did report this to V1 on Sunday (11/17/2024). I do not know when this was reported to the state survey agency. My expectation of staff regarding any type of abuse is to notify V1 the administrator immediately.<br><br>On 11/25/24, at 2:16 PM, V2 (Assistant Administrator) stated, regarding R1 and R4 incident where R4 threw feces at R1, R4 was sent out by involuntary petition to a local hospital. The hospital held her for a period of time. This incident was not reported to the state because we did not have all the details until Monday morning when we investigated. The incident happened on a Sunday (11/17/2024). This incident as of 11/25/2024 still has not been reported to the state survey agency.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | On 11/25/2024, at 11:47 AM, V1 (Administrator) stated, we investigated the incident with R4 throwing feces at R1. We did a full investigation. I will bring the whole binder on it. We did not report it right away as we were not aware of the feces hit the resident. This should be reported. We were made aware last Monday (11/18/24) that feces did hit the resident We did put in an action plan and a removal plan in place and did education for full house. We did abuse/neglect screenings on everyone. The resident (R4) that threw feces is still in the facility. R4 had never done anything like this. R4 has an unrealistic view of discharge and was going through some things. We put R4 in a private room. I do not think R1 went out to hospital. I know she was assessed. This should have been reported to the state survey agency once we found out feces hit R1. The staff handled it well. R1 was cleaned up. In this situation the staff handled the situation well even though we were not 100 percent knowledgeable of extent of the incident. I will bring you the whole binder for this investigation.<br><br>R1 Care plan dated 4/8/24 documents:<br><br>Focus: ABUSE \| NEGLECT \| EXPLOITATION \| TRAUMA<br><br>I am an adult living with chronic health conditions, challenges, and comorbidities.<br><br>Based on the comprehensive facility assessment conducted, there is benefit from placement in a skilled care setting and stability has been demonstrated throughout the admission screening process.<br><br>Denies having been the perpetrator and/or recipient of mistreatment, abuse, neglect, and/or exploitation.<br><br>It is determined that symptomatological factors exist that require monitoring.<br><br>Goals: I will be cared for in a safe manner and verbalize to staff any incidences of abuse or neglect through review date.<br><br>Interventions: Conduct appropriate screening to determine any history of maltreatment including abuse, neglect, living through trauma or surviving combat/violence. Reach and communicate to the resident that their safety, security and dignified care are the priority.<br><br>o Ensure safety if feeling unsafe. [certified nursing assistant (CNA), registered nurse (RN), LPN]<br><br>o Focus on PERSON-CENTERED CARE. Follow person-centered care models affording the resident as much initiative, control and self-determination as possible. Remind the individual that person-centered care or person-first care is a treatment model based upon honesty, sharing valid concerns, integrity and being forthright with care partners.<br><br>o Observe resident in care situations. [LPN,RN]<br><br>o Observe resident when in company of peers. [CNA]<br><br>o Provide reassurance when negative feelings occur. [CNA,LPN]<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | o Recognize that the resident is an adult living with chronic, debilitating comorbidities in a skilled care setting and may experience feelings of lack of control and powerless. Work with the resident to overcome these feelings; advocate for expression of resident rights, autonomy and encourage independent decision making.<br><br>o Report any verbalization of abuse or neglect to administrator immediately.<br><br>[certified nursing assistant (CNA)]<br><br>2.) R2 is an [AGE] year-old resident admitted to facility on 08/07/2024 with medical diagnoses including but not limited to: moderate protein-calorie malnutrition, diabetes mellitus type 2, dementia severe without behavioral disturbance, and adult failure to thrive.<br><br>R2 has a Brief Interview for Mental Status (BIMS) score of 6/15 dated 10/01/2024 which suggests severe cognitive impairment.<br><br>According to minimum data set (MDS) section GG dated 10/01/2024, R2 requires partial/moderate assistance for toileting hygiene, shower/bathe self, upper body dressing, lower body dressing, putting on/taking off footwear and personal hygiene. R2 needs supervision or touching assistance for eating and oral hygiene.<br><br>R2 Care plan dated 10/3/2024 documents:<br><br>Focus: ABUSE \| NEGLECT \| EXPLOITATION \| TRAUMA<br><br>I am an adult living with chronic health conditions, challenges, and comorbidities.<br><br>MODERATE<br><br>Based on the comprehensive facility assessment conducted, there is benefit from placement in a skilled care setting and stability has been demonstrated throughout the admission screening process.<br><br>Denies having been the perpetrator and/or recipient of mistreatment, abuse, neglect, and/or exploitation.<br><br>It is determined that symptomatological factors exist that require monitoring.<br><br>Goals: I will be treated with respect, sensitivity, dignity, and feel safe while I live here in the facility<br><br>Interventions: Conduct appropriate screening to determine any history of maltreatment including abuse, neglect, living through trauma or surviving combat/violence. Reach and communicate to the resident that their safety, security and dignified care are the priority.<br><br>Focus on PERSON-CENTERED CARE. Follow person-centered care models affording the resident as much initiative, control and self-determination as possible. Remind the individual that person-centered care or person-first care is a treatment model based upon honesty, sharing valid concerns, integrity and being forthright with care partners.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Recognize that the resident is an adult living with chronic, debilitating comorbidities in a skilled care setting and may experience feelings of lack of control and powerless. Work with the resident to overcome these feelings; advocate for expression of resident rights, autonomy and encourage independent decision making [social worker (SW)]<br><br>R2 Progress note dated 10/2/24 documents in part:<br><br>Note Text: Resident's behavior/mood noted at This shift. Resident's behavior noted as none noted. Other resident specific behaviors not noted above:<br><br>Behavior triggers: Other resident becoming physically aggressive toward them.<br><br>R3 Progress note dated 10/2/2024 documents: Note Text: Resident's behavior/mood noted at This shift. Resident's behavior noted as was physically aggressive.<br><br>On 11/25/2024, at 10:04 AM, R2 stated, I have not gotten in a fight with anyone. No one has hit me. I have not hit anyone. I do not know anyone by that name. I have not had any problems with anyone that I know of. If I need help, I will use call light, but I don't need help right now. I have not had any injuries. The staff comes to help me to the restroom. I like it here. I don't have any issues here. I am not neglected. I broke my glasses; I have to talk to my daughter when she comes maybe tomorrow. They come and take care of my hip. Resident sitting up in wheelchair watching television. Resident is clean and well groomed. Resident is thin. No foul odors noted.<br><br>On 11/25/2024, at 10:24 AM, R3 stated, I have not gotten in a fight with anyone here. I have not hit anyone, and no one has hit me. No physical abuse or neglect has happened. Staff comes to help me when I hit the call light. I have not had any falls or hurt myself. Resident in bed resting. Resident clean and well groomed. No foul odors noted.<br><br>R2/R3 Investigation 10/2/24 notes in investigation packet document:<br><br>R3 - He tried to hit me, but he did not hit me. I did not hit him. I am not happy about the lights being on and the tv being too loud.<br><br>R2 - He lightly slapped me on the left side/cheek of my face. I did not hit him back. Family notified. Immediately seperated. Room change R3.<br><br>Statement from V7 Registered Nurse (RN) in investigation packet for incident on 10/2/2024 between R2 and R3 documents:<br><br>I was informed by a V8 (CNA) that R3 and R2 was arguing about the television. R3 stated that he wants to sleep but R2 won't turn off the lights and doesn't want to lessen the volume of the television. We immediately separated the R2 and R3 and did room change. R3 stated that he slapped R2 because R2 didn't listen to R3. body assessment done, no injuries. Vital signs checked, within normal limits. Both residents didn't complain of pain. (DON), management, (NP) and family notified.<br><br>Statement from V8 (CNA) in investigation packet for incident on 10/2/2024 between R3 and R2 documents:<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | I heard R2 and R3 yelling at each other about the lights being on and the TV being too loud. R3 wanted R2 to turn his TV down and turn the lights off. I heard R2 say that if R3 hits him again he will hit him back. I separated the residents and informed the nurse who then reached out to the (DON) and administrator.<br><br>On 11/26/24, at 11:27 AM, V3 Director of Nursing (DON) stated, regarding R2 and R3, I know we separated the residents due to a disagreement over TV volume. R2 and R3 were having a disagreement and R2 stated, R3 became physical with him. That is why we initiated separation. Staff did not witness the physical altercation. During investigation it was found to be that R3 slapped/hit R2 on his cheek. I was called on this incident and I notified V1 (Administrator) but my nurse (V7) also notified the abuse coordinator. R3 got sent out for a psychiatric evaluation and returned within 24 hours. I do not recall if R2 was sent out to the hospital. Normally we send the aggressor to the hospital in a situation like this and assess the other resident to see if there is a need to be sent out to hospital. R2 did not have any injuries upon assessment. Family was notified for both R2 and R3. I did not speak to families, but the nurse (V7) did as it is part of our protocol.<br><br>On 11/25/24, at 2:16 PM, V2 (Assistant Administrator) stated regarding R2/R3 incident R2 stated he was hit by resident R3, and it made slight contact with his cheek. We did not send out R2 because during the investigation it seemed like the aggressor would have been R3. Our investigation results were that R2 was hit by R3. R3 denied allegations.<br><br>On 11/26/24, at 09:40 AM, V1 (Administrator) stated, regarding R2 and R3 staff overheard the argument and got the nurse (V7) and separated the R2 and R3. R3 hit R2 so we sent R3 out for psychiatric evaluation. R3 came back stable. We put them in separate rooms. This was the first time R3 had hit anyone. It is hard to gauge intensity, but from what we could tell it was minor but there was contact.<br><br>On 11/25/2024, at 2:23 PM, V7 RN (Registered Nurse) stated, regarding R2 and R3, I remember V8 (CNA) told me that they were arguing because R3 he wanted to sleep around that time, and he wanted to turn off the lights but R2 wanted to watch TV and leave the lights on. V8 went in because they were arguing, and she heard loud voices. As far as I remember it was just a verbal altercation. When I went in there, I immediately separated R2 and R3 to prevent further incident. I informed V3 (DON) right away and V1 (Administrator). I told them that we could change the room of the one resident. R3 was more aggressive. When I got in the room, they were both in the middle of the room. R2 was sitting in w/c watching the TV. R3 was telling R2 to lessen the volume of the TV because R3 couldn't sleep. I do not think it had progressed to anyone putting hands on the other.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | On 11/26/2024, at 2:11 PM V8 (CNA) stated, I do recall the incident between R2 and R3. I was next door from their room and was doing my care for the resident there. I heard R2 and R3 talking back and forth. At first, I thought it was the television. It was getting louder. Then I stopped what I was doing and went next door to See what was going on. R2 and R3 were talking at the same time. R2 and R3 were arguing about the television. R2 said, R3 hit him on his face. He told this to me. I did not tell anyone other than my nurse (V7). I talked to R3 and guided him out of the room. R2 was in his bed. I then told the V7 (nurse) when I was in the hallway talking to R3. I don't remember exactly. V7 may have been at the nurse's station because R2 and R3's room was right by the nurses station. V7 talked to R2 and R3 and we decided to change rooms. I did not hear or witness any hits or slaps or sounds like that. Our abuse coordinator is V1 the administrator. This is an allegation of abuse. Our policy states we are to report any abuse to the administrator(V1). I did not call the V1 because I had reported it to the V7 (registered nurse) so I thought V7 would do it. It didn't dawn on me to report it. I remember V7 texting V1 (administrator) at that time. The last time we had an abuse in-service was last week sometime. V2 (Assistant Administrator) is the one that did the in-service and he did go over that we are all to report to V1 (administrator). I am just used to the nurse reporting it.<br><br>On 11/26/2024, at 12:16 PM, V9 (Social Worker) stated, regarding R3 and R2, I was made aware there was a situation over the TV being too loud. I was told by staff that nobody seen it, but R2 told me that R3 hit him on the cheek. I assessed both residents and followed up with both residents. I moved R3 to a room with a resident that he can better cohabitate with. I gave R2 another roommate that fits well with him. R2 had also told V8 (CNA) that he was hit by R3. Our abuse coordinator I think is V3 (DON). Typically, we go through the DON as well as V22 (Social Worker Director). I was not there when it happened. I did not report to the abuse coordinator. I usually report to my director and my director usually reports to the abuse coordinator from what I know. I know we had abuse training recently; I do not know the exact date but it was about a couple weeks ago.<br><br>Abuse Prevention and Reporting - Illinois Policy dated 11/28/2016 and with last review dated of 12/17/2021 documents (in part):<br><br>Guidelines:<br><br>This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents. In order to do so, the facility 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 abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff and mistreatment of residents.<br><br>This will be done by:<br><br>Orienting and training employees on how to deal with stress and difficult situations, and how to recognize and report occurrences of abuse, neglect, exploitation, and misappropriation of property:<br><br>Resident-to-Resident Abuse (Any type):<br><br>Resident -to-resident altercations that include any willful action that results in physical injury, mental anguish or pain must be reported in accordance with regulations.<br><br>(continued on next page) |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Aperion Care Forest Park | 8200 West Roosevelt Road<br>Forest Park, IL 60130 |

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|---|---|
| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Internal Reporting Requirements and Identification of Allegations:<br><br>Any allegation of abuse or any incident that results in serious bodily injury will be reported to the Department of Public Health immediately, but not more than two hours after the allegation of abuse. Any incident that does not involve abuse and does not result in serious bodily injury shall be reported within 24 hours.<br><br>External Reporting<br><br>Initial Reporting of Allegations:<br><br>When any allegation of abuse, exploitation, neglect, mistreatment, or misappropriation of resident property has occurred, the resident's representative and the Department of Public Health's regional office shall be informed by telephone or fax. Public Health shall be informed that an occurrence of potential abuse, neglect, exploitation, mistreatment, or misappropriation of resident property has been reported and is being investigated.<br><br>Five-day Final Investigation Report: Within five working days after the report of the occurrence, a complete written report of the conclusion of the investigation, including steps the facility has taken in response to the allegation, will be sent to the Department of Public Health. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50036<br><br>Based on observation, interview, and record review the facility failed to report an allegation of resident to resident abuse for two residents (R1, R4) reviewed for abuse.<br><br>Findings include:<br><br>R1 is an [AGE] year-old resident admitted to facility on 2/17/2024 with medical diagnoses including but not limited to: major depressive disorder, moderate protein-calorie malnutrition, adult failure to thrive and age-related osteoporosis.<br><br>R1 has a Brief Interview for Mental Status (BIMS) score of 9/15 dated 10/30/2024 which suggests moderate cognitive impairment.<br><br>According to minimum data set (MDS) section GG dated 10/30/2024, R1 requires substantial/maximal assistance for shower/bathe self, upper body dressing, lower body dressing, putting on/taking off footwear and personal hygiene. R1 is dependent on staff for toileting hygiene. R1 needs partial/moderate assistance for oral hygiene. R1 needs supervision or touching assistance for eating.<br><br>R1 reported an allegation of abuse on 11/19/2024 that had allegedly happened on 11/17/2024 to state surveying agency.<br><br>On 11/25/2024, at 11:47 AM, V1 (Administrator) stated, we investigated the incident regarding R4 throwing feces at R1. We did a full investigation. I will bring the whole binder on it. We did not report it right away as we were not aware that feces hit the resident. This should be reported. We were made aware last Monday (11/18/2024) that feces did hit the resident. We did put in an action plan and a removal plan in place and did education for full house. We did abuse/neglect screenings on everyone. R4 remains in the facility. R4 had never done anything like this before. This should have been reported to the state surveying agency once we found out the feces hit the resident.<br><br>On 11/25/2024, at 2:16 PM, V2 (Assistant Administrator) stated, this incident regarding R4 throwing feces at R1 was not reported to the state because we did not have all the details until Monday (11/18/2024) when we investigated. The incident happened on a Sunday (11/17/2024). This incident still has not been reported to the state surveying agency as of 11/25/24.<br><br>On 11/26/2024, at 11:27AM, V3 (Director of Nursing/DON) stated, regarding situation with R1 and R4, I do recall this was on a Sunday (11/17/2024). Monday (11/18/2024) morning comes and it is thoroughly investigated, and administration got involved. Monday (11/18/2024) it was found out that R4 threw feces at R1. This would be considered abuse. V1 (Administrator) is the abuse coordinator. I did report this to V1 on Sunday (11/17/2024). I do not know when this was reported to the state surveying agency. My expectation of staff regarding any type of abuse is to notify V1 immediately.<br><br>On 11/26/2024, at 1:12 PM, Reportable initial transmission dated 11/25/2024 for incident regarding R4 throwing something at R1 that occurred on 11/17/2024 reviewed. This incident was initially reported 8 days after it occurred.<br><br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Abuse Prevention and Reporting - Illinois Policy dated 11/28/2016 and with last review dated of 12/17/2021 documents (in part):<br><br>Guidelines:<br><br>This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents. In order to do so, the facility 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 abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff and mistreatment of residents.<br><br>This will be done by:<br><br>Orienting and training employees on how to deal with stress and difficult situations, and how to recognize and report occurrences of abuse, neglect, exploitation, and misappropriation of property:<br><br>Resident-to-Resident Abuse (Any type):<br><br>Resident -to-resident altercations that include any willful action that results in physical injury, mental anguish or pain must be reported in accordance with regulations.<br><br>Internal Reporting Requirements and Identification of Allegations:<br><br>Any allegation of abuse or any incident that results in serious bodily injury will be reported to the Department of Public Health immediately, but not more than two hours after the allegation of abuse. Any incident that does not involve abuse and does not result in serious bodily injury shall be reported within 24 hours.<br><br>External Reporting<br><br>Initial Reporting of Allegations:<br><br>When any allegation of abuse, exploitation, neglect, mistreatment, or misappropriation of resident property has occurred, the resident's representative and the (state surveying agency) regional office shall be informed by telephone or fax. (State surveying agency) shall be informed that an occurrence of potential abuse, neglect, exploitation, mistreatment, or misappropriation of resident property has been reported and is being investigated.<br><br>Five-day Final Investigation Report: Within five working days after the report of the occurrence, a complete written report of the conclusion of the investigation, including steps the facility has taken in response to the allegation, will be sent to the (state surveying agency). |

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| F 0623<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34071<br><br>Based on interview and record review, the facility failed to send a copy of the involuntary discharge notice to the ombudsman. This deficiency affects one (R9) of three residents reviewed for transfers and discharges.<br><br>Findings Include:<br><br>R9 is a [AGE] year-old, female, originally admitted in the facility on 07/25/24 with diagnoses of Vascular Dementia, Unspecified Severity, without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance and Anxiety; Schizophrenia, Unspecified; Bipolar Disorder, Unspecified; and Schizoaffective Disorder, Bipolar Type. MDS (Minimum Data Set) dated 07/29/24 recorded R9's BIMS (Brief Interview for Mental Status) of 9, which means moderate impairment in cognition.<br><br>Involuntary transfer/discharge notice dated 11/14/24 was issued to R9 due to safety of individuals in the facility is endangered.<br><br>R9's progress notes documented in part but not limited to the following:<br><br>11/14/24 8:00 AM: R9 continues behaviors and unable to redirect her. R9 hitting, throwing items, staff unable to control behaviors and are fearful. Paramedics were called, transferred out to the hospital.<br><br>11/14/24 3:06 PM: due to the severity of R9's behavior resulting in psychiatric hospitalization , an immediate notice of discharge was issued.<br><br>11/14/24 4:02 PM: V31 (Nurse Practitioner) agreed that R9 was unstable to return to facility and needs to be at a facility that is equipped to manage psychiatric illness.<br><br>(continued on next page) |

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| F 0623<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 11/25/24 at 1:58 PM, V2 (Assistant Administrator) was interviewed regarding R9's involuntary discharge. V2 stated, Last 11/04/24, we sent her out to the hospital for psychiatric evaluation. She was observed with agitation and combativeness. She returned to facility on 11/13/24. The agitation continued as well as the combativeness. She was involuntary petitioned on 11/13/24 where she was sent back to the hospital. She was very, very aggressive to the nurses and staff, but not residents. She came back in stable condition around 5:30 PM. We feel that she was not safe to return, and she was a danger to self and others, so we sent her to another hospital she was sent back to us that evening around 10:30 PM due to not meeting the criteria for admission. That early morning of 11/14/24, V12 (Licensed Practical Nurse/LPN) was unable to redirect her. She (R9) was hitting, throwing items, unable to control behaviors and fearful. Paramedics was called and she was again sent out to the hospital. From there, she was sent to a hospital in another state. That was the time that we issued the involuntary discharge (IVD), meaning she will not be taken back to the facility. We cannot provide interventions for her behavior of violence, aggressiveness. She was with us since July 2024 and absolutely no issues at all with aggression and combativeness. There was no other documentation in her medical record except the IVD notice. I did not give any notice of DC (discharge) to V32 (R9 Representative), only to R9 because there was no address on file. I called the number several times, but he (V32) did not return the call.<br><br>Per R9's Notice of Involuntary Transfer/DC, V32 is listed as representative's name.<br><br>On 11/26/24 at 9:05 AM, V1 (Administrator) was asked regarding involuntary discharge issues to R9. V1 replied, On 11/14/24, she was given an involuntary discharge from facility which means we cannot take her back. Because of the severity of her aggression outweighed my staff skills set to address the aggressive behavior. She was so manic at the time, cops were called. I was contacted by V12 on the day that she was transferred to the hospital by local authorities. I was told that she (R9) had attack her (V12) and she (R9) needs to be restrained because of being violent. I could hear her (R9) screaming in the background during the call. From admission to November, there wasn't any significant behavior that warrants hospital consideration but 11/04/24. She came back on 11/13/24 but continued to exhibit the behavior, so she was sent back to the hospital again, then came back. When we sent her back to hospital, we had not yet determined to do immediate notice of discharge. Just to stabilize her. The behavior escalated again on 11/14/24. In that moment, when I said call the local authorities and take her (R9) over to the hospital, that was not the time the involuntary discharge was issued. When we got in and discussed the situation, that was the time we issued the involuntary discharge. There is no need to involve the physician and they are not responsible for the safety. Maybe the hospital found something, however, it is our regulatory responsibility to care plan for any existing behavior in the event that the behavior would occur again. We did not do the revision of the care plan. We don't have the ability to deal with a resident (R9) who will attack staff that needs physical restrain and would aggressively fight the local authorities. A doctor or psychiatrist job is to stabilize the resident. But even then, I need to address the behavior. Then if I cannot do that, I cannot meet the needs of the residents. Our staff are not trained on how to physically intervene with violent residents. We did not give a 30 - day notice, I couldn't take 5 minutes of her (R9) aggression. We were not able to assist R9 in placement to other LTC (long-term care).<br><br>A review of medical records showed no documentation pertaining to 30-day discharge notice or any notice prior to issuance of involuntary discharge to R9, V32 or V33 (Ombudsman).<br><br>Progress notes dated 11/15/24 documented: left message to notify V33 of R9 involuntary discharge due to behaviors and going to a facility that can accommodate to her psychiatric illness.<br><br>(continued on next page) |

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| F 0623<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 11/26/24 at 1:52 PM, V22 (Social Services Director) was asked regarding notification of R9 involuntary discharge to V33. V22 replied, I notified the ombudsman via phone, but did not send a copy of the transfer.<br><br>Facility's policy titled Discharge Planning dated 10-27-22 documented in part but not limited to the following:<br><br>Discharge planning is the process of creating an individualized discharge care plan, which is part of the comprehensive care plan. It involves the interdisciplinary team working with the resident and resident representative, if applicable, to develop interventions to meet the resident's discharge goals and needs to ensure a smooth and safe transition from the facility to the post-discharge setting. Discharge planning begins at admission and is based on the resident's assessment and goals for care, desire to be discharged , and the resident's capacity for discharge. It also includes identifying changes in the resident's condition, which may impact the discharge plan, warranting revisions to interventions.<br><br>There were no other policies presented by facility in relation to involuntary discharge. |

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| F 0740<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident must receive and the facility must provide necessary behavioral health care and services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34071<br><br>Based on interviews and record reviews, the facility failed to implement an individualized and person-centered care goals and services addressing maladaptive behavior; and failed to establish appropriate activities and therapy programs for a resident diagnosed with mental disorder. This deficiency affects one (R9) of one resident reviewed for behavior and behavior management.<br><br>Findings include:<br><br>R9 is a [AGE] year-old female, originally admitted in the facility on 07/25/24 with diagnoses of Vascular Dementia, Unspecified Severity, without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance and Anxiety; Schizophrenia, Unspecified; Bipolar Disorder, Unspecified; and Schizoaffective Disorder, Bipolar Type. MDS (Minimum Data Set) dated 07/29/24 recorded R9's BIMS (Brief Interview for Mental Status) of 9, which means moderate impairment in cognition.<br><br>Involuntary transfer/discharge notice dated 11/14/24 was issued to R9 due to safety of individuals in the facility is endangered.<br><br>R9's progress notes documented in part but not limited to the following:<br><br>11/03/24 at 1:10 PM - behavior as verbally aggressive.<br><br>11/03/24 at 10:26 PM - verbally and physically aggressive; resistive to care.<br><br>11/04/24 at 6:23 AM - wandering; verbally and physically aggressive; socially inappropriate. Pulled shirt up while at nurses' station and displayed breast. Pulled CNA (Certified Nursing Assistant) hair; poured water on nurse from water pitcher; profanity used towards staff; threw walker; ran down the hall yelling loudly; left floor in the elevator after being asked not to leave; Interventions - 1:1 with staff.<br><br>11/04/24 at 1:02 PM - petitioned out to hospital for psychiatric evaluation. Observed R9 with agitation and combativeness throughout shift.<br><br>11/12/24 at 3:17 PM - returned to facility.<br><br>11/13/24 1:57 PM- had been petitioned out to hospital for psychiatric evaluation. R9 was observed with agitation and combativeness throughout shift. R9 threw her walker across the dining hall, picking up her walker and hitting staff with the walker. R9 attempted to launch out towards staff but was successfully separated by nursing staff and redirected back to her assigned room.<br><br>11/13/24 5:30 PM R9 arrived from hospital via wheelchair in stable condition. Transferred to another hospital for further evaluation.<br><br>11/13/24 8:43 PM - made a call with hospital, R9 will come back to facility and deferred admission for R9 do not meet the criteria.<br><br>(continued on next page) |

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| F 0740<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 11/14/24 8:00 AM: R9 continues behaviors and unable to redirect her. R9 hitting, throwing items, staff unable to control behaviors and are fearful. Paramedics were called, transferred out to the hospital.<br><br>11/14/24 3:06 PM: due to the severity of R9's behavior resulting in psychiatric hospitalization , an immediate notice of discharge was issued.<br><br>11/14/24 4:02 PM: V31 (Nurse Practitioner) agreed that R9 was unstable to return to facility and needs to be at a facility that is equipped to manage psychiatric illness.<br><br>In an interview conducted on 11/25/24 at 1:41 PM, V6 (Social Worker) was asked regarding R9's behavior. V6 replied, Weeks ago, around weekend, she was sent out for psych evaluation because she was throwing herself to the floor, throwing things on the floor. She did not come back. I don't know why she is no longer here in the facility. They did not tell me why and I did not ask. Social Services is responsible for the behavior care plan. The first-time behavior, we document it. If it is a consistent behavior, then we care planned. The throwing herself to the floor and throwing things on the floor were first time behavior. We did not do updates or revisions on the care plans. When she came back, we did not do any revisions on the care plan.<br><br>On 11/25/24 at 1:58 PM: V2 (Assistant Administrator) was also asked regarding R9. V2 stated, Last 11/04/24, we sent her out to the hospital for psychiatric evaluation. She was observed with agitation and combativeness. She returned to facility on 11/13/24. The agitation continued as well as the combativeness. She was very, very aggressive with the nurses and staff, but not residents. She came back in stable condition around 5:30 PM. We feel that she was not safe to return, and she was a danger to self and others so we sent her to another hospital, but she was sent back to us that evening around 10:30 PM due to not meeting the criteria for admission. That early morning of 11/14/24 she was again unable to be redirected. She was hitting, throwing items unable to control behaviors and are fearful. She was again sent out and issued the involuntary discharge, meaning she will not be taken back to the facility. We cannot provide interventions for her behavior of violence, aggressiveness. She was with us since July 2024 and absolutely no issues at all with aggression and combativeness. It just came out that these behaviors were manifested.<br><br>Per progress notes dated 11/03/24, R9 was already observed with physical and verbal aggression.<br><br>(continued on next page) |

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| F 0740<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 11/26/24 at 10:58 AM, V12 (Licensed Practical Nurse) was asked regarding R9 and R9's behavior. V12 stated, I am her regular nurse. She is alert oriented, knows what is going on, knows her name and knows the place but not time of day. She had some aggression, yelling out a couple of times. She has a behavior of throwing a chair, her gait is not good. She yells and intimidating in a way. The usual intervention for her behavior is one on one, approach her, calm her down, reapproach her, ask for her needs. Redirect her. On 11/14/24, she was sent out to the hospital earlier that day. When I came on duty, I was told that she is returning back because the hospital did not admit her. She came back. Not long after she came back, she started becoming verbally aggressive towards staff, babbling a lot of her birthday. It was her birthday that day, 11/14. She came to the nurses' station, really loud. So, I redirected her back to her room and asked if she want to lay down, but she was very into her birthday. She didn't go back to her room and told us about her birthday again. Me and another staff were there. We were not interested in her birthday, so she got mad again. It was around 1 AM. She got so mad that she was grabbing and throwing things to the floor. I told her to please stop it, but she didn't listen. She continued the aggression and combativeness. At that point, I told her to still stop and cut it out, I fanned my hands to protect myself. But she got so mad again and threw a chair down the hall. There were no residents at the time. She was so violent, and I don't want to get close to her. She didn't listen. We kept on saying stop but she was saying bi*****s, racial slurs, going Spanish and English talking. There was not much anything that I can do except stand there and verbalized to her to stop; give directions not to fall but she won't listen. Other staff from another floor must have heard the commotion so she was taken downstairs for a bit and after a while she came back to her room. Her roommate (was identified as R12) started to yell because she (R9) took her brush and threw it on the floor. At that point, I went to her room. She (R9) was standing there and R12 was so upset. I asked what happened, R12 said her brush was thrown. I asked R9, Did you throw her brush? She (R9) did not answer, stared at me, and then hit me in the face. I had my glasses on, and it got ruined that I cannot see. At that point, we hold her and lowered her to the floor because she was completely out of control. We cannot handle her anymore; she was totally combative and aggressive. I called V1 (Administrator), V3 (Director of Nursing) and V13 (Assistant Director of Nursing). I told V1 everything and was advised to call hospital. I asked him (V1) on what we need to do in case her behavior did not stop, we will call emergency. Ambulance took her to the hospital. I didn't have the chance to see her care plan for behavior. We were not in-serviced/trained to handle violent behaviors.<br><br>R9's care plans documented the following:<br><br>Potential for adverse side effects related to antidepressant therapy, potential for exacerbation of signs and symptoms of bipolar disorder:<br><br>Interventions (initiated 07/26/24, revision 11/22/24):<br><br>Encourage activities to provide diversion and distraction.<br><br>Observe for/document/report PRN (when needed) adverse reactions to antidepressant therapy: change in behavior/mood/cognition; hallucinations/delusions; social isolation, suicidal thoughts, withdrawal; decline in ADL(activities of daily living) ability, continence, no voiding; constipation, fecal impaction, diarrhea; gait changes, rigid muscles, balance problems, movement problems, tremors, muscle cramps, falls; dizziness/vertigo; fatigue, insomnia; appetite loss, weight loss, nausea/vomiting, dry mouth, dry eyes.<br><br>(continued on next page) |

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| F 0740<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Observe/record/report to MD (Medical Doctor) PRN mood patterns signs and symptoms of depression, anxiety, sad mood as per facility behavior monitoring protocols.<br><br>Refer to psychiatrist or psychologic for evaluation or follow up as needed.<br><br>Report unusual behavior. Report change in physical condition.<br><br>Potential for complications related to use of psychotropic medications, potential for exacerbation of signs and symptoms of Schizophrenia:<br><br>Interventions (initiated 07/26/24, revision 11/22/24):<br><br>Encourage activities to provide diversion and distraction.<br><br>Observe for/document/report PRN any adverse reactions of psychotropic medications: unsteady gait, tardive dyskinesia, EPS (extrapyramidal symptoms) (shuffling gait, rigid muscles, shaking); frequent falls, refusal to eat, difficulty swallowing, dry mouth, depression, suicidal ideations, blurred vision, diarrhea, fatigue, insomnia, loss of appetite, weight loss, muscle cramps, nausea, vomiting, behavior symptoms not usual to the person.<br><br>Observe for/record occurrence of for target behavior symptoms such as pacing, wandering, disrobing, inappropriate response to verbal communication, violence/aggression towards staff/others etc. and document per facility protocol. Observe/record/report to MD PRN mood patterns signs/symptoms of depression, anxiety, sad mood as per facility behavior monitoring protocols.<br><br>Refer to psychiatrist or psychologist for evaluation or follow up as needed.<br><br>Report unusual behavior. Report change in physical condition. Report change in appetite.<br><br>Have been determined by comprehensive assessment to have care needs that require the support/services provided in this care setting at this time. Discharge (DC) potential and DC planning needs have been assessed by the IDT (interdisciplinary team). Barriers to DC include clinical conditions that require this care setting for highest practical functioning, mobility issues, psych illness and dysfunction, inability to care for self, not having funds for a private duty:<br><br>Interventions (initiated 08/05/24, revision 10/08/24):<br><br>I will be provided care to enable me to be able to function at my highest most practical level that will support my stay in a homelike environment.<br><br>I will be provided opportunity to express any thoughts or feelings that I may have regarding this and work with the clinical team on addressing any concerns that may surface during my stay at the facility.<br><br>I will meet with my social worker as required to help with my adjustment to the facility and to the LTC (long-term care) environment.<br><br>(continued on next page) |

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|---|---|---|---|
| | 145969 | A. Building<br>B. Wing | 11/27/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Aperion Care Forest Park | 8200 West Roosevelt Road<br>Forest Park, IL 60130 |

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| F 0740<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | If requested/required; Social Services (SS) will send a referral to an alternative skilled home for transfer and/or if discharging to home, SS will send a referral to the home health care company of my choice, durable medical equipment company, home care services company, meals on wheels, according to orders received from the clinical team to facilitate a successful discharge to the community.<br><br>While at the present I require the care and support/services that this facility setting provides in order to achieve my highest practical functioning; I am connected to psychological services to address macro and micro areas of dysfunction and will continue to work with psychological services and SS to achieve clinical objectives, eliminate barriers to DC so that when clinically able to DC and successfully reside in the outside community.<br><br>On 11/26/24 at 12:08 PM, a follow interview was conducted with V6 (Social Worker) regarding R9's behavior care plan. V6 stated, I don't have any behavior care plan for R9.<br><br>On 11/26/24 at 4:14 PM, V3 was interviewed regarding care plans. V3 replied, We have clinical meetings every day and we discussed risk management like skin concerns, behaviors and falls. It incorporates the IDT, therapy also, we review any incidents and collaboratively decide what intervention in the care plan is added. We try to get to it as soon as we can. We discussed behaviors and we update and revise behavior care plan. We have standard staff meeting every morning and staff informs me of any behavior concerns on residents. We do assessments on residents further evaluate the behavior and then IDT discussed the concern. For R9, she was having behavior issues this November, 2024. We discussed it. I don't recall if we did an update with the care plan.<br><br>There was no specific behavior care plan in R9's medical record.<br><br>R9's care plan on activities, revision date 10/08/24 indicated her interest in bingo game. Interventions recorded were as follows:<br><br>Educate staff, resident, family, and visitors of COVID 19 (Coronavirus 19) signs and symptoms and precautions.<br><br>Follow facility protocol for COVID 19 screening/precautions.<br><br>Observe for psychosocial and mental status changes document and report as indicated.<br><br>Observed for signs and symptoms of COVID 19 document and promptly report signs and symptoms: fever, coughing, sneezing, sore throat, respiratory issues.<br><br>There were no additional interventions in R9's activity care plan specifically related to activities.<br><br>On 11/27/24 at 11:17 AM, V29 (Activity Director) was asked regarding R9's activities. V29 stated, She has mental illness, she is still able to participate in activity for a short period of time. It's more like one on one music therapy, reminiscing; nail care; reading and listening books/CDs (compact discs) regarding stories; relaxation activities. She is not on any group therapy or counseling therapy. Hers is more on one on one activities. She is on bingo activities.<br><br>R9's MDS dated [DATE] also recorded:<br><br>(continued on next page) |

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| F 0740<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Sec F - F0500. Interview for Activity Preferences<br><br>A. How important is it to you to have books, newspapers, and magazines to read? - 2. Somewhat important<br><br>B. How important is it to you to listen to music you like? - 1. Very important<br><br>C. How important is it to you to be around animals such as pets - 2. Somewhat important<br><br>D. How important is it to you to keep up with the news? - 2. Somewhat important<br><br>E. How important is it to you to do things with groups pf people? - 2. Somewhat important<br><br>F. How important is it to you to do your favorite activities? - 2. Somewhat important<br><br>G. How important is it to you to go outside to get fresh air when the weather is good? 2. Somewhat important<br><br>H. How important is it to you to participate in religious services or practices? 2, somewhat important<br><br>R9's Preadmission Screening and Resident Review (PASRR) dated 06/24/24 documented the following:<br><br>Scored 21 on the short blessed cognitive test, which reveals cognitive impairment.<br><br>Services and supports nursing facility staff required to provide:<br><br>Rehabilitative services: You will need to be provided the following services and/ or supports:<br><br>Service or Support<br><br>Consistent implementation during the resident's daily routine and across settings, of systematic plans which are designed to change inappropriate behaviors.<br><br>Development, maintenance, and consistent implementation across settings of those programs designed to teach individuals daily living skills necessary to become more independent and self-determining including, but not limited to grooming, personal hygiene, mobility, nutrition, vocational skills, health, drug therapy, mental health education, money management and maintenance of the living environment.<br><br>Crises intervention services or plan to assist when you have thoughts of hurting others.<br><br>Individual, group, and family psychotherapy<br><br>Development of appropriate personal support networks<br><br>Formal behavior modification programs.<br><br>(continued on next page) |

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| F 0740<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Facility's policy titled Behavioral Health Services dated 10/24/22 stated in part but not limited to the following:<br><br>Purpose: To establish a system for identifying behaviors and implementing appropriate interventions consistent with the individualized plan of care and to ensure that each resident receives appropriate treatment and services to attain the highest practicable mental and psychosocial well-being.<br><br>Services:<br><br>Mental health rehabilitative services and behavior management program for mental illness (MI) and Intellectual disabilities (ID) and other related disorders such as Substance Use Disorder and residents with a history of trauma and/or post-traumatic stress disorder may include, but are not limited to the following:<br><br>Consistent implementation during the resident's daily routine and across settings, of systematic plans which are designed to change inappropriate behaviors while maximizing the resident's dignity, autonomy, privacy, socialization, independence, choice, and safety;<br><br>Crisis intervention service<br><br>Individual, group, and family psychotherapy<br><br>Development of appropriate personal support networks<br><br>Formal behavior modification programs<br><br>Suggested Interventions/Approach:<br><br>The behavior interventions outlined below are intended to be used only as suggested guidelines for behavior management. Each resident and situation should be considered on an individual basis, depending on the nature of the behavior and risk of harm to self or others.<br><br>When inappropriate or distressed behavior occur, interventions should be implemented by utilizing the least restrictive or least intrusive measures first and evaluating the effectiveness of these interventions before utilizing more restrictive or intrusive interventions.<br><br>Initial Measures: (Least restrictive/intrusive)<br><br>1.If not in a quiet familiar area, consider relocation to appropriate space, own room, or other space.<br><br>2.When resident's voice is loud, offer drink, food, toileting, take for a walk or redirect to activity of interest, i.e. TV, tactile, stimulation, music, aromatherapy, or conversation.<br><br>3.Observe resident for behavior escalation of anxiety, aggression such as loud voice tone, hand ringing, swearing, yellowing, and/or other irritability.<br><br>Interventions if Behaviors Escalates and/ or Reoccurs:<br><br>(continued on next page) |

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| F 0740<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 4.Remove from problem area, separate from others when necessary. Approach the resident from the front.<br><br>5.Allow time to calm down with 1:1 explanation of why behavior is inappropriate and unacceptable in a calm, soft voice.<br><br>6.Allow time for resident to voice feelings and frustration.<br><br>If uncontrolled anger, aggression or anxiety cannot be redirected, i.e. the resident is in danger of harming self or others after attempting the above interventions, the following, may be implemented by or under the direct supervision of a licensed nurse, physician or psychiatrist: (most restrictive/intrusive)<br><br>7.Administer physician-ordered PRN medication for the symptoms being exhibited. If there are no PRN medications ordered, notify the physician to obtain appropriate orders.<br><br>9.Document all interventions attempted, including medication administered and the resident's response medical interventions.<br><br>10.Notify the physician of the resident's signs/symptoms and lack of response to medications and other interventions as indicated.<br><br>Development and Review of Care Plan:<br><br>The facility will attempt to identify, to the extent possible, any previous history of mental illness, trauma, abuse, substance abuse, comorbidities, pattern of behaviors, preferences, interests, daily routines, medication use and effective behavior management interventions in developing an individualized care plan.<br><br>The care plan should include a well-defined problem-statement and should outline the goals of care. It should include measurable objectives and timetables for individualized interventions. It should also identify the responsibilities of various staff to implement the approaches effectively.<br><br>In developing the plan of care, the interdisciplinary team, in collaboration with the resident or family/representative, reviews the results of the assessment and cause identification above in order to develop individualized, person-centered interventions. Staff should determine, in collaboration with the practitioner, resident, and family/resident representative if and why behaviors should be addressed (e.g. severely distressing to resident and unrelieved by other approaches or interventions).<br><br>Individualized, person-centered approaches should be implemented to address expressions of distress.<br><br>The plan of care shall be reviewed and/ or updated at least quarterly and with a change in condition such as new or worsening behavior or a behavior event requiring increased monitoring, reporting to Risk Management or state agencies, or implementation of new interventions.<br><br>Training<br><br>(continued on next page) |

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| F 0740<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Nurse aides are required to complete and provide documentation of training that includes, but is not limited to, competencies in areas such as:<br><br>Communication and interpersonal skills<br><br>Promoting residents' independence<br><br>Respecting residents' rights<br><br>Caring for the residents' environment<br><br>Mental health and social service needs and<br><br>Care of cognitively impaired residents<br><br>Additional training may be provided for direct care staff and managers upon hire, annually or as deemed necessary. Examples may include, but are not limited to:<br><br>Dealing with challenging behaviors; appropriate interventions and behavior management techniques for cognitively impaired/dementia or psychiatric residents.<br><br>Communication techniques (Dementia and non-dementia residents).<br><br>Facility's policy titled, Comprehensive Care Plan dated 11-17-17 documented in part but not limited to the following:<br><br>Purpose: To develop a comprehensive care plan that directs the care team and incorporates the resident's goals, preferences, and services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.<br><br>Guidelines:<br><br>The facility will develop and implement comprehensive person-centered care plan for each resident, consistent with the resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.<br><br>The comprehensive care plan must describe the following:<br><br>Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. |