STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145981	A. Building B. Wing	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Swansea Rehab Health Care	1405 North Second Street Swansea, IL 62226

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50628 Based on interview and record review the facility failed to prevent abuse for 3 of 3 residents (R2, R5 and R8) reviewed for abuse in the sample of 14. This failure placed these residents at risk for physical and psychological harm. Findings include: 1. On 9/3/24 at 10:30 AM V1, Administrator provided two reportable incidents of resident-to-resident physical altercations with the perpetrator in both incidents identified as R5. R5s Undated face sheet documented R5 was admitted to the facility on [DATE] with diagnoses of schizophrenia, depression, legally blind, HTN, Parkinson's disease, tardive dyskinesia, learning disorder, dementia with behaviors, severe alcohol abuse, hepatic steatosis, HLD and diabetes. R5's Minimum Data Set (MDS) dated [DATE] documents R5 is moderately cognitively impaired, experiences hallucinations, requires a w/c for mobility, and requires substantial assist with ADLs. This assessment also documents R5 is always continent of bowel and bladder. R5's care plan dated 6/22/2023 documents: Impaired cognition as related to diagnosis of schizophrenia, developmental delay, dementia. Evidenced by confused and mumble low when talking. Resident's specific information: resident is unable to hold a conversation during interviews or staff interactions. This care plan was updated on 3/29/24 with, (R5) is blind with aggressive behaviors. R5 picked up yellow floor sign and hit another resident in the head. Both residents separated and yellow floor sign removed. Intervention: 1. staff notified resident that he is not allowed to grab/ hold anything (signs)in his hands or behind his back in wheelchair. 2. psychiatrist notified for medication changes. R5s care plan was updated again on 4/3/24: resident open hand slapped another resident at nurse's station. The interventions for this were: 1. 1:1 monitoring, and 2. psychiatrist notified for medication changes. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145981	A. Building B. Wing	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Swansea Rehab Health Care	1405 North Second Street Swansea, IL 62226

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R5's progress notes documented on 3/29/24 at 11:50 AM R5 took a wet floor sign and hit another resident (R2) in dining area. R5 was then brought to the nurse's station. Ativan 1 mg(milligram) PRN (as needed) given. Psychiatry called and order received to send to (local hospital). At 3:07 pm, hospital called and stated they would not be able to directly admit R5 due to resident's needs. The plan was for R5 to go to ER for treatment and then return to the facility. At 11:30 pm, R5 returned to facility without any further behaviors noted. R5s progress notes dated 4/3/2024 at 1:32 pm documented that R5 hit another resident in the face when the other resident, (R8) came to R5 asking for something to eat. At 2:05 pm, orders were received to send R5 to local hospital for evaluation and treatment. At 2:50 pm, ambulance here to transfer to (local hospital) and report called. POA notified at 3:16 pm. At 9 pm, R5 returned to facility in good spirits. R5's progress note dated 4/4/2024 at 9:45 AM documents a new order to increase his Depakote to 500 mg twice daily. There were no medication changes after R5 hit R2 on 3/29/24. On 9/3/2024 at 9:55 am, R5 is observed sitting out at nurse's desk slumped in wheelchair, drooling and mumbling. R5 was verbalizing repeated statements. When R5 was asked if he has ever had an incident with another resident, R5 stated, I never hurt anyone. He denied that anyone has ever hurt him. R5 denied that he has been scared. R5's hospital records dated 3/29/24 document his diagnosis as violent behavior. No medications or prescriptions were given. 2. R2s undated face sheet documented that R2 was admitted to the facility on [DATE] with diagnoses of chronic obstructive pulmonary disorder, (COPD), gastroesophageal reflux disease, (GERD), hyperlipidemia, (HLD), hypertension, (HTN), Rheumatoid arthritis, congestive heart failure (CHF), acute ischemic heart disease, Peripheral artery disease, cerebral vascular accident, (CVA), renal artery stenosis, myocardial infarction, Vitamin B12 deficiency, major depressive disorder, peripheral vascular disease, and rheumatoid arthritis. R2's MDS dated [DATE] documents R2 is severely cognitively impaired, requires a wheelchair for mobility, and is dependent for Activities of Daily Living (ADLs). This assessment also documents R2 is always incontinent of bowel and bladder. R2's Care plan dated 6/1/23 documents : Impaired Cognitive related to moderate impairment BIMS (Brief Interview for Mental Status) 9 evidenced by forgetfulness confusion. This care plan was updated on 3/29/24 with: confrontation with another resident (R5) resulting in a bruise to the forehead, cut to bridge of nose, and cut to upper left eyebrow. Area was cleaned and steri-strips applied. R2 was sent to emergency room for evaluation. R2's progress notes dated 3/29/24 documented that R2 was involved in a physical altercation with another resident in the dining room. Nurse practitioner was notified and R2 sent to emergency room (ER) for further evaluation. Ambulance arrived at 12:50 pm and resident returned to facility at 5:20 pm. Nurse practitioner and power of attorney made aware of return. R2 diagnosis from ER included hematoma of scalp and abrasion of face. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145981	A. Building B. Wing	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Swansea Rehab Health Care	1405 North Second Street Swansea, IL 62226

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/3/2024 at 9:50 AM, R2 was lying in bed and speaks with mumbled words. When asked name, she did not respond with intelligible responses. When asked if R2 had any incidents with other residents, she responded that she had not with the word no. R2 also responded no that no one has hurt her or that she is scared. The Facility Reported Incident dated 3/29/24 documents on 3/29/24, R5 allegedly struck R2 in the face with a wet floor sign. The nurse immediately assessed R2 and R2 was sent to ER to evaluate and treat for abrasion obtained across bridge of nose and small hematoma above left eye with noted purplish discoloration to left eye. Both residents were immediately separated and R5 was sent to hospital per psychiatrist. Appropriate changes have been made. Will continue with frequent monitoring. Both care plans have been updated. On 9/5/24 at 8:50 AM, interview with V1, administrator was asked if she remembered the altercation between R2 and R5. She stated that she remembered he (R5) had taken the wet floor sign from behind his back. R2 and R5 were separated immediately and assessed. R2 was monitored and kept in a high traffic area to monitor closely. V1 reported that abuse training is performed annually. Staff is to report the abuse immediately and separate residents. The need to call family representative and make them aware of what happened. On 9/5/24 at 9:10 AM, V4, LPN, interviewed. V4 stated she was the nurse providing care to R5 that day. V4 stated that R5 had the sign behind his back. R5 had previously told staff that the sign between his back and the wheelchair helped his back. V4 stated that the interventions include that R5 is at the nurse's station where he can be closely monitored, and he is not allowed to have any signs. V4 stated that he has had medicine changes and has been evaluated by the psychiatrist. V4 stated that R5 used to get mad but now he is mellow and more controlled. 3. R8's undated face sheet stated that R8 was admitted to the facility on [DATE] with diagnoses of Alzheimer's Disease, HTN, HLD, ASHD (Arterial Sclerotic Heart Disease), hypothyroidism and major depression. R8's MDS dated [DATE] documents that R8 requires a wheelchair for mobility, is dependent for all ADLs and is always incontinent of bowel and bladder. R8's care plan dated documents problems including but not limited to: hard of hearing, wandering, self-care deficit, range of motion, severe cognitive deficits, depression, self-injury risk, hypertension, pressure ulcer risk, and impaired cognition with a history of inappropriate behavior. The goal of the last problems is that R8 will calmly accept redirection during episodes of inappropriate behavior and reduce the number of episodes. The interventions for this include to initiate behavior monitoring program to identify patterns, staff to introduce self upon contact and explain all procedures, during periods of inappropriate behavior, use a calm approach, and try to determine source of agitation, maintain a calm environment , allow R8 time to express self, administer psychotropic medication as ordered by physician, remove to a quiet environment, and assess physiological needs and seek to resolve. R8s update to care plan dated 4/3/24 document that R8 was hit with open palm by another resident (R5). No injuries noted after removing R8 from the nursing station. 1:1 monitoring initiated for the safety of the resident. Power of attorney notified of face slap. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145981	A. Building B. Wing	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Swansea Rehab Health Care	1405 North Second Street Swansea, IL 62226

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R8's progress notes dated 4/3/24 documents R8 was in an altercation with another resident (R5). POA (Power of Attorney) and MD (Medical Doctor) notified. Complete head to toe assessment done with no abnormal findings. No injuries noted. R8 denied any pain. The Facility Reported Incident dated 4/3/24 documents R8 was sitting at the nurse's station stating she wanted something to eat and R5 struck R8 in the face with the back of his hand. The altercation was witnessed by staff. In conclusion, the facility has determined that the altercation was without injury Both residents were separated immediately and placed on 1:1 monitoring. Medication has been reviewed with psychiatrist; Appropriate changes have been made. Will continue with frequent monitoring. Both resident care plans have been updated to reflect status. On 9/5/24 at 8:45 AM, interview with V2, DON, stated that inservices are performed with instructions provided as when to report abuse. She added that abuse has to be reported to the administrator/ director of nurses immediately 24 hours a day, 7 days per week. V2 added that there is no window of time for this. On 9/5/24 at 8:55 AM, interview with V13, LPN, stated that she was not here during the incidents. She stated that she has received abuse training. In the event of a physical abuse occurring, she stated she would separate the residents and move the aggressor. She would contact the administrator and do a report. If someone is hurt, she would notify the physician and then follow their orders. On 9/5/24 at 9:00 AM, interview with, V14, CNA, doesn't remember the altercation between R2/R5 and R5/R8. V14 stated that she receives abuse training through the facility and if an altercation occurred, she would immediately report it to her nurse. The facility's policy, Abuse Prevention Program, updated 10/2006 stated that the facility affirms the right of their residents to be free from abuse and neglect. The policy therefore prohibits mistreatment or abuse of its residents and has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of mistreatment, or abuse of their residents. This includes orienting and training employees on how to deal with difficult situations and how to recognize and report occurrences of mistreatment and abuse immediately to supervisory personnel. Training on activities that constitute abuse. Establishing an environment that promotes resident security and prevention of mistreatment. Identifying occurrences and patterns of potential mistreatment and abuse of residents. Dementia management and resident abuse prevention. Implementing systems to investigate all reports and allegations of mistreatment and abuse of residents promptly and aggressively and making the necessary changes to prevent future occurrences. This facility is committed to protecting our residents from abuse by anyone. The facility desires to prevent abuse, by establishing a resident sensitive and resident secure environment.