| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 146046 | A. Building<br>B. Wing | 04/01/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Marshall Rehab & Nursing | 410 North Second Street<br>Marshall, IL 62441 |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for 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** 31642<br><br>Based on observation, interview and record review, the facility failed to protect residents' right to be free from physical abuse of R3 by R2 and R4. This failure affects three (R2,R3,R4) of five residents reviewed for abuse on the sample list of eight.<br><br>Findings include:<br><br>1.) R3's Minimum Data Set (MDS) dated [DATE] documents R3's Brief Interview of Mental Status (BIMS) score of two out of a possible 15 indicating, severe cognitive impairment<br><br>R2's Brief Interview of Mental Status (BIMS) assessment dated [DATE] documents R2 has a score of 15 out of a possible 15, which indicates no cognitive impairment.<br><br>The facility Illinois Department of Public Health (IDPH) Final Report Incident Date: 2/23/2025 signed by V1, Administrator/Abuse Prevention Coordinator, documents the following: Summary; Received report that (R2) resident, struck (R3) resident. They were immediately separated without any apparent injuries (right cheek injury documented below) .<br><br>R2's Nursing Progress Note dated 02/23/2025 at 12:30 pm, and signed by V6, Licensed Practical Nurse (LPN), documents the following: Note Text : Resident has been up to the nursing desk several times calling (V20, Family Member) and (V22, Family Member). No one answered the phone. Resident (R2) is becoming angry. Another resident sitting buy (by) the assignment board (R3), and he (R2) became physically aggressive with her (R3). Separated the two (R2 and R3). Assessed resident (R3) for any injuries, she has a red mark on her right upper cheek. Took v/s (vital signs) and assisted her to bed to relax. The DON (Director of Nursing) and the Administrator (V1, Abuse Prevention Coordinator) was (were) notified.<br><br>R3's Nursing Progress Note dated 02/23/2025 at 5:24 pm documents: Note Text: Resident remains resting in bed. Awakens easily. Right upper cheek remains red. Denies any tenderness to the area at this time (four hours and 54 minutes after the above physical abuse was documented).<br><br>(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 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 3/26/25 at 12:50 pm , R2 propelled his wheelchair into his room, over to the side of his bed, and transferred himself. R2 laid semi-Fowler back onto his bed. R2 stated I sure can tell you what the hell went on. (R3) was touching my arm in the dining room earlier that day. I was in a pissed off mood after getting off the phone. I saw her sitting across from the nurse's station. I remembered earlier in the dining room she was tapping on my arm. I went over to her. I (R2) hauled off and busted her (R3) in the eye, just like this (R2 raised his elbow up to his shoulder level, tightened his fist, and punched into the air). It is the law. If someone hits you first, you can hit them back. She (R3) tapped my arm several times earlier in the day. I (expletive, f***ing) hit her (R3), once with my fist. Staff took her away somewhere and that ended that. R2 then stated She (R3) wanders in the dining room and does the same thing, to other residents too. She (R3) is tapping peoples arms all the time. I was sick of it, she is annoying. That one punch is how I let her know. I have had no problems with her since.<br><br>On 3/26/25 at 1:34 pm V6, LPN stated I witnessed (R2) getting mad. He wants to go home. He had been asking to use the portable phone repeatedly that day. His family (unidentified) will not answer the phone. He was getting frustrated, that escalated to real angry because he couldn't reach his family. Then everybody (residents and staff) went to the dining room, residents to eat lunch and staff to serve it. I was passing medication on halls A and B (unit's divided by a nurses station). I had just finished med pass (medication administration) and he (R2) came up to use the phone again. His family still did not answer. He was really upset again. Very angry. (R3) was seated in her wheelchair across from the nurse's station, 12 to 15 feet away from (R2). (R2) wheeled his wheelchair over to (R3's) wheelchair. His room is right down B hall. I thought he (R2) was just going to pass in front of her (R3). (R3) had her hands in her lap. I was looking right over at them, He raised his arm, to his shoulder level. His hand was fisted. He hit her on her upper right cheek. Her whole cheek was red. It happened really fast. He (R2) knew what he was doing, and (R3) was not doing anything. Me (V6, LPN) and (V10, Certified Nursing Assistant) (sic) separated them. She took him (R2) to his room and educated him, that he could not hit anyone. That is abuse. We took (R3's) vital signs. She was upset. She is not a talker but put both her hands on her face. I did a skin assessment and laid her in bed. I checked on her again and again. I gave her roommate (R8) medication and checked on (R3) again then too. (R3) was sleeping by then, about a half hour later. (R3's) right upper cheek was still red.<br><br>On 3/26/25 at 2:05 pm V10, CNA stated It was a rough day. I was here. He (R2) was having a bad day trying to call his family. He called repeatedly. Then ate a meal. He tried again to reach his family. (V6, LPN) helped him with the phone down there (points to the opposite end of the nurses station). (R3) was seated in her wheelchair across from the nurses station right here (V10, points approximately 12 feet away from where she said R2 had used the phone). (R3) had her hands in her lap. She (R3) was looking around and I was standing up here (three feet away) talking to her. He (R2) was really upset not reaching his family on the phone. I could hear his (R2) raised voice but could not make out what he said. He (R2) wheeled his wheelchair in the direction of his room. I thought he was going to pass (R3) up. He (R2) suddenly drew up his fist and hit (R3) in the right check. When I realized what had happened, I took him immediately away to his room, and (V6, LPN) was taking care of (R3). I saw (R3) put her hands up over her face and made a loud sound. She (R3) then said 'he (R2) hit me'. When (V6, LPN) and I (V10, CNA) put her to bed, She was scared. I sat with her in her room for a while. I (V10) kept telling her (R3) I would keep her safe. She was clingy and very nervous. It just broke my heart. (V6, LPN) reported to the (V1, Abuse Prevention Coordinator)Administrator. The DON (V2, Director of Nursing) and (V13, CNA) were here and notified (V1) too, as soon as we made sure the resident was safe.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 3/28/25 at 12:00 pm V13, CNA stated confirmed she was present when R2 hit R3 in the eye. V13 stated the physical abuse of R3 by R2 happened on a Sunday 2/23/25, V13 did not work on Monday 2/24/25. V13, CNA also stated I worked Tuesday (2/25/25) or Wednesday (2/26/25) after that happened. (R3's) eye and cheek were still dark red with a purple tint. (two and three days after R2 hit R3).<br><br>2.) R3's Minimum Data Set (MDS) dated [DATE] documents R3's Brief Interview of Mental Status (BIMS) score of two out of a possible 15 indicating, severe cognitive impairment.<br><br>R4's MDS dated [DATE] documents R4's BIMS score of 15 out of a possible 15, indicating no cognitive impairment.<br><br>R5's MDS dated ,d+[DATE] documents R5's BIMS score of 14 out of a possible 15, indicating no cognitive impairment.<br><br>The facility Illinois Department of Public Health (IDPH) Final Report Incident Date: 2/24/2025 signed by V1, Administrator/Abuse Prevention Coordinator, documents the following: On February 24th, 2025, it was reported by resident (R5) that resident (R4) struck resident (R3) on the arm. The residents were in the dining room for dinner when (R3) approached (R4) multiple times. (R3) enjoys greeting all of the residents. patting them on the hand, leg and arm as if to greet them. (R4) had eventually gently steered (R3) wheelchair away from him. (R3) did not make any indications at the time of experiencing any pain.<br><br>The same report documents: There were not any employees present at the time of this interaction.<br><br>On 3/26/25 at 12:20 pm, R4 stated (R3) when she comes into the dining room, she comes and reaches for other people's food. When I interrupt her, I started batting at her. I don't think I made contact with her, though. If I did hit her, it didn't hurt her. I had to push her wheelchair away from me twice, before she would stay away from me. That is all I did on that day you're referring to (2/24/25). R4 also stated I am not the only one that has a problem with her. We (unidentified) even ask her is a nice way. I'd just try to turn around and go on with what I'm doing. Sometimes I have to swat at her to get her to leave me alone. I can't think of any of the other resident name, off the top of my head, but there are several she gets on their nerves too. I don't remember names very well, but others can tell you the same thing about her (R3). Yes, I (R4) have raised my voice telling her to get the hell away from me. If staff are around, they take her (R3) to the far table, and lock her wheelchair brakes. There are times she still scoots her wheelchair over to people. Even with the brakes locked. There are staff around that see it all the time. There are other times when there aren't any staff in the dining room at all, until it's time to serve food. They come in and out bringing people in the dining room for meals.<br><br>There have been many times going down the hall she (R3) starts slapping at me. Staff see it, I tell them too. They (unidentified staff) say she doesn't know what she is doing ( R3 has severe cognitive impairment). They say just ignore her. I don't feel I have ever been abusive to her. She (R3) is just annoying to have to deal with this every day.<br><br>On 3/27/25 at 10:25 am V2, Director of Nursing (DON) stated V1 Administrator / Abuse Prevention Coordinator told V2, DON about the allegation that R4 hit R3, but she was not working the day it happened. V2, DON then stated R4 'is educated constantly' that R3 has Dementia and does not know what she is doing. He is alert and oriented, he needs to leave the situation and find a staff member.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 3/28/25 at 1:00 R5 stated I witnessed (R4) getting mad at (R3), raising his (R4) fist up and acting like he was going to follow threw and hit (R3) in the head. She (R3) was about two feet from him (R4). That (hit her in the head) didn't happen. He (R4) hadn't hit her (R3) yet. (R3) wheeled her wheelchair up closer to where (R4) was sitting. (R4) turned around and pushed (R3's) wheelchair backwards. He pushed it hard. He is a lot bigger than she is. I bet she doesn't weigh one hundred pounds. He is a bigger guy, even when seated in a wheelchair. She (R3) flew in her wheelchair backwards, about eight feet. There were no staff anywhere around. I looked (for staff) for a minute or two. Then, I watched (R4) as (R3) approached (R4) table. (R3) gave him (R4) a little pat on the arm to get his attention. She (R3) barely touched him (R4). (R3) was not being aggressive in any way. She is very sweet and was being kind to him. (R4) purposely struck (R3) on the upper arm. I (R5) saw it all. You could hear he (R4), slapped her (R3) hard. He then, forcefully pushed R3's wheelchair again, but not as far (eight feet prior in this interview) as he had. He (R4) yelled 'get the hell out of here'. (R3) looked stunned as she propelled herself away to the other end of the dining room. It was definitely, abuse. There is no way around that. I went immediately out to find a staff member (unidentified). I can't remember who it was I told. Several staff came into the dining room right away. The staff are few and far between at mealtimes. They are all getting people out of their rooms, and bringing them to the dining room. I was eating about eight feet away from (R4), facing him (R4). I saw every bit. He (R4) hates her with a passion, and I don't know why. Her little hand, was a tender tap. She is very loving. Nothing he (R4) should be so upset about. He knows exactly what he is doing. She has Dementia, and doesn't understand what she is doing.<br><br>The facility (facility name) RESIDENTS RIGHT TO FREEDOM FROM ABUSE, NEGLECT, AND EXPLOITATION POLICY AND PROCEDURE policy dated 2025, documents the following:<br><br>PURPOSE<br><br>To ensure that all of (Facility name) residents are free from abuse, neglect, misappropriation of their property, and exploitation.<br><br>POLICY<br><br>The facility's residents have the right to be free from abuse, neglect, misappropriation of their property and exploitation as defined in this policy. This includes, but is not limited to, freedom from corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the residents medical symptoms. This policy applies to any and all owners, directors, officers, clinical staff, employees, independent contractors, consultants, and others currently or potentially working for the Facility ("Associates).<br><br>PROCEDURE<br><br>III. The Facility shall review altercations from resident to resident as a potential situation of abuse.<br><br>A. Staff shall monitor for any behavior that may provoke a reaction by residents or others, which include, but are not limited to:<br><br>a. Verbally aggressive behavior, such as screaming, cursing, bossing around/demanding, insulting to race or ethnic group, intimidating;<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | b. Physically aggressive behavior, such as hitting, kicking, grabbing, scratching, pushing/shoving, biting, spitting, threatening gestures, throwing objects. |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>31642<br><br>Based on record review and interview the facility failed to recognize and report reasonable suspicion of a crime to a law enforcement agency, related to physical abuse of R3 by R2 and R4, and failed to recognize and report suspicion of a crime to a law enforcement agency of an allegation of sexual abuse of R1 by V4, R1's Visitor. These failure affects four (R1,R2,R3,R4) of five residents reviewed for abuse on the sample list of eight.<br><br>Findings include:<br><br>The facility facsimile Incident Report Form - IDPH ( Illinois Department of Public Health) Notification) dated 2/23/25 signed by V1, Administrator/Abuse Prevention Coordinator documents: The facility received an allegation of physical abuse that R2 struck R3.<br><br>The same form documents the police were not notified. As part of this investigation V6, Licensed Practical Nurse witness statement documents V6 observed R2 hit R3 in the face leaving a red mark on R3's cheek.<br><br>The facility facsimile Incident Report Form - IDPH ( Illinois Department of Public Health) Notification) dated 2/24/25 signed by V1, Administrator/Abuse Prevention Coordinator documents: The facility received an allegation of physical abuse that R4 struck R3.<br><br>The same form documents the police were not notified. As part of the same investigation, R5's witness statement documents R5 observed R4 hit R3 on the upper arm, and R5 heard a pop.<br><br>The facility facsimile Incident Report Form - IDPH (Illinois Department of Public Health) Notification) initial report dated 3/25/25 signed by V1, Administrator/Abuse Prevention Coordinator documents: The facility received an allegation of sexual assault that (R1) was sexually assaulted on 3/17/2025 by an employee (with the same first name as a family friend of R1's).<br><br>The same form documents the police were not notified.<br><br>On 3/27/25 at 9:40 am V1, Administrator / Abuse Prevention Coordinator stated I did not call the police on any of the three allegation (V4 to R1, R2 to R3 and R4 to R3). I did not know I was supposed to. I thought I just reported to IDPH right away, and then I finished my investigation within five days. It makes sense to report all three, since one was a sexual abuse (R1) allegation and two (R3 by R2, and R3 by R4) could be considered allegations of battery.<br><br>The facility Resident Right To Freedom From Abuse, Neglect, And Exploitation Policy And Procedure dated 2025 documents: The facility will ensure compliance with the Elder Justice Act pursuant to the Facility's Elder Justice Act Policy and Procedure.<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 - Some | The facility The Elder Justice Act and Reporting Suspected Crimes Against Residents Policy and Procedure protocol dated 2025 documents: PURPOSE; To facilitate efforts to prevent, detect, treat, intervene in, and prosecute elder abuse, neglect, and exploitation and to protect elders with diminished capacity while maximizing their autonomy and their right to be free of abuse, neglect, and exploitation.: The same policy documents: Reasonable suspicion of a crime must be reported to the State Survey Agency and at least one local law enforcement agency. Procedure: I.<br><br>Definitions<br><br>A. Alleged violation is defined as a situation or occurrence that is observed or reported by staff, resident, relative, visitor, another health care provider, or others but has not yet been investigated and, if verified, could be noncompliance with the Federal requirements related to mistreatment, exploitation, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property.<br><br>a. An alleged violation can be observed or reported by staff, resident, relative, visitor, another health care provider, or others.<br><br>b. An individual (e.g., a resident, visitor, facility staff) who reports an alleged violation to the Facility staff does not have to explicitly characterize the situation as abuse, neglect, mistreatment, or exploitation in order to trigger reporting requirements. Rather, if the Facility staff could reasonably conclude that the potential exists for noncompliance with the Federal requirements related to mistreatment, exploitation, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property, then it would be considered reportable. The same policy documents: C.Abuse<br><br>a. The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish.<br><br>b. The deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being.<br><br>c. Instances of abuse of all residents, irrespective of any mental or physical condition, that cause physical harm, pain or mental anguish. This includes verbal abuse, sexual abuse, physical abuse, and mental abuse, including abuse facilitated or enabled through the use of technology.<br><br>i. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.<br><br>ii. Sexual abuse is non-consensual sexual contact of any type with a resident.<br><br>e. Abuse includes resident to resident altercations, including, but not limited to any willful action that results in physical injury, mental anguish, or pain.<br><br>f. Willful actions include, but are not limited to the following:<br><br>i. Hitting;<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 - Some | ii. Slapping;<br><br>iii. Punching;<br><br>iv. Choking;<br><br>v. Pinching;<br><br>vi. Biting;<br><br>vii. Kicking;<br><br>vii. Throwing objects;<br><br>ix. Grabbing;<br><br>x. Shoving. |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Respond appropriately to all alleged violations.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31642<br><br>Based on observation, interview and record review the facility failed to remove<br><br>R2, the perpetrator of physical abuse, from direct access with R2's vulnerable, dependent, non-verbal roommate R6. This failure affects two (R2,R6) of five residents reviewed for abuse on the sample list of eight.<br><br>Findings include:<br><br>R2's Brief Interview of Mental Status (BIMS) assessment dated [DATE] documents R2 has a score of 15 out of a possible 15, which indicates no cognitive impairment.<br><br>R3's Minimum Data Set (MDS) dated [DATE] documents R3's Brief Interview of Mental Status (BIMS) score of two out of a possible 15 indicating, severe cognitive impairment<br><br>R6, MDS dated [DATE] documents R6 has severe cognitive impairment and is totally dependent of staff for all activities of daily living and does not ambulate<br><br>R6's Diagnoses List last updated 01/16/25 documents the following: Cerebral Palsy, Quadriplegia, Unspecified, Metabolic Encephalopathy, Adjustment Disorder With Anxiety, Major Depressive Disorder Recurrent, Unspecified, and Adjustment Insomnia<br><br>R2's Nursing Progress Note dated 02/23/2025 at 12:30 pm, and signed by V6, Licensed Practical Nurse (LPN), documents the following: Note Text : Resident has been up to the nursing desk several times calling his (V20, Family Member) and his son. No one answered the phone, Resident (R2) is becoming angry. Another resident sitting buy (by) the assignment board (R3) and he (R2) became physically aggressive with her. Separated the two (R2 and R3). Assessed resident (R3) for any injuries she has a red mark on her right upper cheek. Took v/s (vital signs) and assisted her to bed to relax. The DON (Director of Nursing) and the Administrator (V1, Abuse Prevention Coordinator) was (were) notified.<br><br>On 3/26/25 at 12:48 pm , R6, (R2's roommate) was in a reclined geriatric type wheeled chair parked next to R6's bed. R6's gestured with spastic movements and made inaudible sounds. R6 did attempt to converse and shook his head back and forth, yes, he feels safe and no one has hurt him. R2 then closed his eyes as if to sleep.<br><br>On 3/26/25 at 12:50 pm, R2 wheeled his wheel chair into his room and transferred himself to bed. R2 confirmed he was anger and hit R3 in the eye on 2/23/25.<br><br>On 3/26/25 at 1:34 pm V6, Licensed Practical Nurse (LPN) stated V6 LPN witnessed R2 hit R3 on the right cheeks leaving a red mark. V6 also stated she had talked to V1, Administrator/ Abuse Prevention Coordinator and wanted to move R2 to a different room, because R6, R2's roommate was still in their shared room. V1, Administrator /Abuse Prevention Coordinator told V6, LPN that if (R2) had any more aggressive behaviors, staff could send him to the hospital.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 146046 | A. Building<br>B. Wing | 04/01/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Marshall Rehab & Nursing | 410 North Second Street<br>Marshall, IL 62441 |

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

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 3/26/25 at 2:05 pm V10, Certified Nursing Assistant stated I worried about (R6), (R2's) roommate. (R6) couldn't defend himself. He is totally dependent on staff for everything. (V1, Administrator/Abuse Prevention Coordinator) gave the direction for us not to move them to a different rooms. (V6, LPN) the nurse and I would really worried. Actually everybody here was really worried. I have never seen (R2) do anything to another resident. He has been mad and yelling at staff. We had just witnessed the outburst with (R3), and felt he needed to be moved to a different room, away from (R6) . He (R2) stayed in his room the rest of the shift watching tv (television). He did come out for supper, but we watched him extra close. When he went back to his room, I looked in there several times just to make sure he wasn't doing anything toward (R6) He didn't. He knew he had to have staff with him to come out of his room.<br><br>On 3/27/25 at 9:40 am V1, Administrator / Abuse Prevention Coordinator confirmed R6, R2's roommate remained in their shared room overnight, on the night R2 hit R3 on 2/23/25.<br><br>The facility (facility name) RESIDENTS RIGHT TO FREEDOM FROM ABUSE, NEGLECT, AND EXPLOITATION POLICY AND PROCEDURE policy dated 2025, documents the following:<br><br>: B. IV. When the Facility has identified abuse, the Facility will take all appropriate steps to remediate the noncompliance and protect residents from additional abuse immediately. The Facility will increase enforcement action, including, but not limited to:<br><br>A. Taking steps to prevent further potential abuse . |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>31642<br><br>Based on interview and record review the facility failed to maintain complete and accurate medical records for two (R3,R4) of five residents reviewed for abuse on the sample list of eight.<br><br>Findings include:<br><br>1.) R2's Nursing Progress Note dated 02/23/2025 at 12:30 pm, and signed by V6, Licensed Practical Nurse (LPN), documents the following: Note Text : Resident has been up to the nursing desk several times calling (V20, Family Member) and (V22, Family Member). No one answered the phone. Resident (R2) is becoming angry. Another resident sitting buy (by) the assignment board (R3), and he (R2) became physically aggressive with her (R3). Separated the two (R2 and R3). Assessed resident (R3) for any injuries, she has a red mark on her right upper cheek. Took v/s (vital signs) and assisted her to bed to relax. The DON (Director of Nursing) and the Administrator (V1, Abuse Prevention Coordinator) was (were) notified.<br><br>R3's Nursing Progress Note dated 02/23/2025 at 5:24 pm is the only documentation in R3's chart that refers to R3's reddened facial area and does not mention the physical abuse noted above. R3's Progress note documents: Note Text : Resident remains resting in bed. Awakens easily. Right upper cheek remains red. Denies any tenderness to the area at this time (four hours and 54 minutes after the above physical abuse was documented).<br><br>R3's complete electronic medical records does not documents the above physical abuse occurred, measurements of the red mark on R3's face, family or physician notification, and there is no ongoing assessments alert charting' or monitoring of R3 response to the physical abuse by R2.<br><br>On 3/26/25 at 1:34 pm V6, Licensed practical Nurse (LPN) confirmed she did not measure R3's reddened face, therefor did not document the skin impairment measurement, when R3 was hit in the face by R2. V6 also confirmed she did not document the physical abuse by R2 in R3's chart. V6 also confirmed she did not document that V1, Administrator/Abuse Prevention Coordinator was notifying the physician and families V6, LPN also acknowledged V6, LPN should have initiated 72 hour assessments post the abuse on 2/23/25.<br><br>On 3/28/25 at 1:50 pm V3, Assistant Director of Nursing/Wound Nurse stated I complete assessments and document the measurement on a spread sheet and on the resident assessment in pcc (electronic medical record) in resident chart. (R3) has had bruises in the past. I did not know she had a red area on her face that needed measured. I did not look at her skin the day of the incident with (R2), but I don't remember seeing anything the next day, so I did not document an assessment, because I saw nothing. Our floor nurses are supposed to initiate 72 hour documentation after skin issues. I don't see that happened.<br><br>(continued on next page) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 2). The facility Illinois Department of Public Health (IDPH) Final Report Incident Date: 2/24/2025 signed by V1, Administrator/Abuse Prevention Coordinator, documents the following: On February 24th, 2025, it was reported by resident (R5) that resident (R4) struck resident (R3) on the arm. The residents were in the dining room for dinner when (R3) approached (R4) multiple times. (R3) enjoys greeting all of the residents, patting them on the hand, leg and arm, as if to greet them. (R4) had eventually gently steered (R3) wheelchair away from him. (R3) did not make any indications at the time of experiencing any pain.<br><br>R3's complete electronic medical records does not documents the above physical abuse by R4, family or physician notification, and there is no ongoing assessments alert charting' or monitoring of R3 response to the physical abuse by R4.<br><br>R4's complete electronic medical records does not documents the above physical abuse of R3, family or physician notification, and there is no ongoing assessments alert charting' or monitoring of R4.<br><br>On 4/1/25 at 1:00 pm V2, Director of Nursing stated When you (surveyor) entered the building to investigate the allegations of abuse (R2 hit R3 and R4 hit R3), I reviewed their charts. I talk to (V6, Licensed Practical Nurse) and asked her why she did not document (R3) was hit by (R2), in (R3's) chart. She acknowledged she should have documented in both charts. I also saw (R4) had nothing in his chart about the incident between him and (R3), nor did (R3). Documentation is expected to be complete including notifications of family and physician. Though both situations were reported to the (V1, Administrator/Abuse Prevention Coordinator) and she called the families and physician, the nurse should have documented that (V1) was doing the notifications. Ongoing behavior tracking was completed for (R2 and R4's) behaviors. On (R3) there needed to be follow-up for signs and symptoms of fearfulness and her red bruise measurements and tracking. I saw one follow up note with (R3) redness documented, the next day I believe. There should have been 72 hour follow-up charting as I mentions to you before. Documentation is not a new issue but will still be addressed in the next staff meeting.<br><br>The facility policy Policy and Procedure, Charting and Documentation dated 11/05/2019<br><br>documents the following: Purpose<br><br>To maintain a medical record to serve a legal document that details the services provided to the resident, or any changes in the resident's medical or mental condition, through charting and documentation.<br><br>Each resident will have an active medical record that contains accurately documented information, systematically organized and readily accessible to authorized persons.<br><br>The same policy documents:<br><br>10. Documentation will include information on assessment, notifications, interventions and evaluation including but not limited to:<br><br>a. Incidents/Accidents per facility policy<br><br>b. Change in condition per facility policy<br><br>(continued on next page) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | c. Physician notification<br><br>d. DPOA/Responsible Party notification<br><br>e. Refusal of medications/treatment or recommendations<br><br>The same policy documents:<br><br>11. Additional documentation requirements will be followed:<br><br>d. Alert Charting - documentation on incident/accident or change in condition for 72 hours or until stable. |