| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 146134 | A. Building<br>B. Wing | 04/17/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Saline Care Nursing & Rehab | 120 South Land Street<br>Harrisburg, IL 62946 |

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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** Based on interview and record review, the facility failed to prevent resident to resident physical abuse for 2 of 4 residents (R1, R3) reviewed for abuse in the sample of 4.<br><br>The past non-compliance occurred between 03/31/25 and 04/07/25.<br><br>Findings include:<br><br>1. R1's admission Record dated 04/17/25 documents an admission date of 05/04/24 with diagnoses including traumatic subdural hemorrhage, bipolar disorder, anxiety disorder, heart failure, unspecified osteoarthritis, and chronic kidney disease. R1's Minimum Data Set (MDS), dated [DATE], documents in Section C a Brief Interview for Mental Status (BIMS) score of 12 which indicates R1 has moderately impaired cognition. Section GG documents R1 is independent with most ADL (Activities of Daily Living) functions. R1's Care Plan documents a focus area of Peer pushed resident to the ground before staff could intervene with a date initiated of 03/31/25. Interventions for this focus area include: 1. N.O (new order) received for new pain medication, 2. Peer was removed from the area. Resident was assessed for injuries by charge nurse. 3. Per facility protocol MD (Medical Doctor) and Administrator updated r/t (related to) incident. N.O. received for (Local Mobile X-ray) Xray. 4. Resident was sent to (Local Hospital) for evaluation r/t complaints of pain. Negative findings with x-rays of lumber spine and hips. 5. Staff to attempt to limit contact between the two residents. Social Service or designee to follow up with resident to ensure that he feels safe in his home.<br><br>R2's admission Record dated 04/17/25 documents an admission date of 02/23/21 with diagnoses including: Major Depressive Disorder, anxiety disorder, insomnia, Paranoid schizophrenia, and unspecified psychosis. R2's MDS dated [DATE] documents in Section C a BIMS score of 15 which indicates R2 is cognitively intact. Section GG documents Supervision and set-up help with ADL functions. R2's Care Plan documents a focus area of (R2) pushed peer before staff could intervene r/t reside got in his face. Date initiated 03/31/25. Interventions for this focus area include: 1. 1:1 completed with resident (BIMS score 15) related to inappropriateness of actions and the need to get to charge nurse or CNA (Certified Nurse Assistant) to discuss issues he is having with peer, to leave the area and talk with staff. 2. MD and Administrator notified of incident. Social Service spoke with resident. 3. MD updated related to event and medication change ordered fluid restriction added. 4. Staff immediately separated the 2 residents.<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 | R1's Progress Notes dated 03/31/25 at 7:14AM by V8 (Assistant Director of Nursing/ADON) documents in part (R1) in dining room by serve out station. Heard a thump from a cup hitting the ground. Then heard residents yelling back and forth. Staff Attempted to intervene. Before this writer could make it to the residents, (R1) was in the motion of falling backwards. (R1) fell backward and landed on buttocks. Peer immediately removed from dining room. (R1) assessed with complaint of hip pain. No contact with head.<br><br>R2's Progress Note dated 03/31/25 at 7:13AM by V4 (Licensed Practical Nurse/LPN) documents This writer was passing medications when I heard some commotion behind me. (R2) slammed his cup down on the table and it flew on the floor, and he started yelling. Other resident (R1) started yelling back at resident. Staff tried to intervene between both residents. (R2) pushed (R1) down on the ground. (R1) fell on back. (R2) was removed from the dining room until further notice. This writer contact (Psychiatric NP) and Informed (R2's Primary Physician) of resident to resident.<br><br>A Report titled Illinois Department of Public Health Initial Report dated 04/05/25 at 7:00AM documents: Date of Incident 03/31/25. Time of Incident 7:00AM. Resident Name: (R1) and (R2). Final report: (R2) a 67 y/o (year old) male with a diagnosis of Paranoid schizophrenia within the dining room when he had a verbal issue with a peer. (R1) a 75 y/o male with a diagnosis of bipolar disorder. (R2) then made contact with (R1) and (R1) stepped back and lost his balance. Both residents were assessed by nursing. (R2) is alert to self with a BIMS of 15 and is ambulatory without devices. (R2) is on a 1800cc (cubic centimeters) fluid restriction. (R2) was in the dining room and was holding a coffee cup when he threw the cup onto the floor. (R2) was upset that he could not have multiple cups of coffee due to his fluid restriction. (R2) was very delusional and making statements about the coffee and who owns the coffee and informed administrator later that (R1) told him that he owned the coffee, and he could not have any of his coffee. (R1) is alert to self and has a BIMS score of 12 and is ambulatory. (R2) thought that (R1) said that he could not have any coffee. (R2) then became more delusional and made contact with (R1) resulting in him stepping backwards and losing his balance. (R1) fell onto his back. Residents were separated and both were assessed. (R1) complained of pain in his hip and was sent for x-rays and were negative. The (Psychiatric Nurse Practitioner) was notified of the incident and reviewed both residents' medications. (R2) has been very delusional, and a medication increase has been initiated. The administrator spoke with (R2) and he stated that he was upset that peer stated that he owns the coffee and that he could not have any. Explained to resident that he is on fluid restriction and that he had all the coffee that was allowed on the restriction and that he needed to follow the physician orders and informed him that the peer does not own the coffee. Social Service will meet with (R1) 3 times a week for 2 weeks. (R2) had the medication changed and will be monitored for 14 days. Social Service will meet with (R2) 3 times a week for 2 weeks both charts and behavior tracking have been reviewed.<br><br>On 04/16/25 at 10:25AM, R1 stated that he did have an altercation with R2 on 03/31/25. R1 stated that R2 was in the dining room yelling and hitting his coffee cup on the counter and then threw the coffee cup. R1 said he told R2 to stop hitting his cup and throwing it. R1 said that R2 then turned around and shoved him and he fell on his buttocks and back. R1 said after he fell, he was having some pain, and the nursing staff did send him over to the local hospital to be checked out and they didn't find any breaks or fractures.<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 04/16/25 at 12:21PM, R2 stated that he remembers the day that him and R1 got into an altercation on 03/31/25. R2 said that he was wanting another cup of coffee, and he was trying to get staff to give him another cup. R2 said staff was telling him that he couldn't have another cup right that second. R2 said that he got mad and threw his coffee cup and then R1 got in his face and told him he didn't need to be doing all that. R2 said that R1 was a bigger guy, and he didn't want him in his face, so he pushed R1 back and R1 fell. R2 said that he knows that he should not have pushed R1. R2 said that he was mad about not getting his coffee and when R1 got in his face and was much bigger than him he wanted R1 out of his face and just tried to get him away from him not make him fall.<br><br>On 04/16/25 at 12:23PM, V4 (Licensed Practical Nurse/LPN) stated she was working on 03/31/25 when R1 and R2 had an altercation. V4 said R2 was in the dining room and had already had a cup of coffee and he is on a fluid restriction. V4 said that R2 was hitting his cup on the table and threw his cup and then R1 got up and walked over to R2 and told R2 he didn't need to be hitting his cup and throwing things. V4 said that R1 was close to R2's face and R2 kept telling R1 to get out of his face. V4 said that R1 went to step back and fell. V4 said that she didn't see R2 push R1. V4 said that R2 had been having increased delusions for the past couple of days and seemed more agitated. V4 said that after the altercation she did contact the psychiatric Nurse Practitioner and she gave a new order to increase R2's medication related to the increased delusions.<br><br>2. R3's admission Record dated 04/17/25, documents an admission date of 11/12/21 with diagnoses including: Alzheimer's, major depressive disorder, other schizophrenia, generalized anxiety, and pica in adults. R3's MDS dated [DATE] documents in Section C under staff assessment for mental status short term memory problems and long-term memory problems. Section GG documents walking as supervision. R3's Care Plan documents a focus area in part of (R3) will wonder the halls, she will pace from one side of the unit to another with a date initiated of 10/27/24. Documented interventions include: 1. Attempt bringing resident to a high visibility area. 2. Redirect resident when wandering into other residents' rooms. 3. (R3) wanders on the unit sometimes will have accident with her bowels while she is wandering. She does not like to wear a brief she will take it off.<br><br>R4's admission Record dated 04/17/25 documents an admission date of 11/27/20 with diagnoses including: schizoaffective disorder, vascular dementia, anxiety, and obstructive and reflux uropathy. R4's MDS dated [DATE] documents in Section C a BIMS score of 15 which indicates R4 is cognitively intact. Section GG documents Supervision with most ADL functions. R4's Care Plan documents a focus area of (R4) has delusions 5X's a week Dx (diagnosis) : schizoaffective disorder, generalized anxiety disorder with a date initiated of 11/20/24. Documented interventions include: 1. (R4) has delusions 5x's a week attempt to turn conversations to reality based. 2. Offer snacks or drink 3. Offer resident to sit outside weather permitting. Another focus area of (R4) is/has potential to be verbally aggressive date initiated of 05/22/24. Documented interventions include: 1. Administer medications as ordered. Monitor/document for side effects and effectiveness 2. Analyze of key times, places, circumstances, trigger, and what de-escalates behavior and document. 3. Assess and anticipate resident needs, food thirst, toileting needs, comfort level, body positioning, pain, etc.<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 | A Report titled Illinois Department of Public Health Initial Report dated 04/13/25 at 8:00PM documents date of incident 04/07/25 and time 10:00AM. Residents Name R3 and R4. Final report: On 04/07/25 at 10:00AM staff witnessed (R4) 71 y/o male with a diagnosis of schizoaffective disorder and vascular dementia, make unwanted contact with (R3) 71 y/o female with a diagnosis of Alzheimer's, while in the hallway. Residents were immediately separated and assessed for injuries. No injuries were noted to either resident. (R4) is up and ambulatory on the unit. (R4) is alert with a BIMS of 15. (R4) was coming out of the bathroom when he saw a peer, (R3) walking down his hall. Per staff (R4) then makes contact with (R3's) chest area after he came out of the bathroom. Staff immediately separated the residents. (R4) denied that anything happened, but then stated he would not do that again. (R3) is up ambulatory throughout the unit. (R3) is alert to name and a BIMS is unable to be completed. (R3) went down a hall that she normally does not ambulate down when a peer, (R4) came out of the bathroom and made contact with (R3's) chest area. Staff intervened and assisted (R3) from the area. (R3) was assessed by the nurse with no injuries noted. The physician was notified, and a urinalysis was ordered as (R4) was making some delusional statements. The urinalysis was positive, and the physician has ordered medication. An appointment is scheduled for 04/22/25 for an appointment with urologist. Social Service meet with (R4) 3 times a week for 2 weeks. (R4's) chart and behavior charting have been reviewed. (R3) had no injuries. (R3's) chart and behavior charting have been reviewed. Social service to meet with (R3) 3 times a week for 2 weeks. (R3) is on 15-minute checks.<br><br>R3's Progress Note dated 04/07/25 at 11:07AM by V6 documents in part Housekeeper came to nurse to inform resident had been hit in the chest by peer. Housekeeper stated, 'Peer came out of the bathroom and went up to (R3) and hit her in the chest' housekeeper immediately separated them.<br><br>On 04/16/25 at 12:35PM, R4 stated he does remember the altercation between him and R3 on 04/07/25. R4 stated that R3 kept coming down his hallway which is an all-males hallway. R4 said that he told R3 that she needed to go back to her hallway. R4 said that he went to the bathroom and when he came out of the bathroom that R3 was right there. R4 said that he pushed R3 in the chest to get her to go back to her hallway. R4 said that he did not hit R3 in the chest, but that he did push her. R4 said that he would never hurt anyone on purpose. R4 said that he did have an infection in his urine which was probably making him not act like himself that day.<br><br>On 04/17/25 at 1:15PM, V13 (Housekeeper) stated that R4 got to the bathroom to brush his teeth and when he came out of the bathroom R3 was coming down the hall. V13 said that R4 was telling R3 that it wasn't her hall that that she needed to go back to her hallway. V13 said that R4 then pushed R3 in the chest area and told her that she needed to go back to her hallway. V13 said that she couldn't tell how hard R4 pushed R3 in the chest. V13 said that R4 was just trying to get R3 back to her hallway.<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 04/17/25 at 2:00PM V1 (Administrator/ADM) stated that after R1, R2, R3, and R4's altercations that they have social service meet with those residents 3 times a week for 2 weeks. V1 said they did medication reviews on R1, R2, R3, and R4. R2's medication was increase related to his delusions per the Psychiatrist Nurse Practitioner. V1 said that R3 was placed on 15 Minute checks to monitor her. R1 and R2 no longer sit at the same table and are not allowed on the same hallway. V1 said that R4 was checked for a urinary infection, and he was positive for a urinary tract infection and R4 is currently being treated with antibiotics and has an appointment to see a urologist on 04/22/25. V1 said that R1 and R2 are not allowed to smoke at the same time. V1 said that the facility has taken every step to try to prevent any further altercations between these residents and all residents. V1 said that they try doing increased activities to help keep residents busy. V1 said that on 03/31/25 they had an IDT (Interdisciplinary Team)/QA (Quality Assurance) Meeting to discuss the altercation between R1 and R2. V1 said they also had an IDT/QA meeting on 04/07/25 to discuss R3 and R4's altercation.<br><br>The facility policy titled Abuse Prevention dated 08/16/2019 documents The facility affirms the right of our residents to be free from abuse, neglect, misappropriation of resident property, corporal punishment, and involuntary seclusion. This facility therefore prohibits mistreatment, neglect, or abuse of its residents and has attempted to establish a resident sensitive and resident secure environment.<br><br>Prior to the survey date, the facility took the following actions to correct the non-compliance:<br><br>1. Social service to meet with R1, R2, R3, and R4 3 times a week for 2 weeks.<br><br>2. R1 and R2's medications were reviewed on 03/31/25 and R2 received a medication increase on Divalproex sodium which is used to treat his paranoid schizophrenia.<br><br>3. R1 and R2 have been moved to different tables in the dining room and on halls since 03/31/25.<br><br>4. R1 and R2 have different smoke times initiated on 03/31/25<br><br>5. R3 was placed on 15-minute checks on 04/07/25.<br><br>6. R4 was checked for urinary tract infection on 04/07/25.<br><br>7. The facility had an IDT/QA meeting on 03/31/25 to discuss the altercation between R1 and R2. In attendance was V1 (Administrator), V10 (Assistant Administrator), V2 (Director of Nursing/DON), V8 (Assistant Director of Nursing/ADON), V11 (Infection Preventionist/IP), V3 (Social Service/SSD), and V12 (SSD). Notes document in part The psychiatric NP (Nurse Practitioner) was notified of the incident and reviewed residents' medications. R2 is on a fluid restriction and becomes very upset when he cannot have extra drinks. R3 has been very delusional, and a medication increase has been indicated and will be monitored for 14 days. A root cause R2 upset over fluid restriction and not being able to have more coffee and becomes more delusional when he thought R1 stated that he owned the coffee and could not have any. R2 reminded that he needs to follow physician orders for his fluid restriction.<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 | 8. The facility had an IDT/QA meeting on 04/07/25 to discuss that altercation between R3 and R4. In attendance was V1, V10, V2, V8, V11, V3, and V12. Notes documents in part R3 had no injuries. R3's chart and behavior charting were reviewed. Social service will meet with her 3 times a weekly for 2 weeks. R3 is on 15-minute checks. Cause is R3 was walking on a different hallway and R4 was having increased delusions related to UTI (Urinary Tract Infection). R4's physician was notified, and a urinalysis was ordered as R4 was making some delusional statements. The urinalysis was positive, and the physician has ordered medication. An appointment is scheduled for R4 on 04/22/25 for an appointment for urologist. Social service will meet with R4 3 times a week for 2 weeks. R4's chart and behavior charting have been reviewed. Root cause is R4 has increased delusions r/t UTI. |