| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 14E812 | A. Building<br>B. Wing | 10/03/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Mount Vernon Health Care Center | #5 Doctors Park<br>Mount Vernon, IL 62864 |

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 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>41610<br><br>Based on interview, observation and record review the facility failed to provide a safe and sanitary environment for residents to shower for 20 (R7 - R26) of 20 residents reviewed for environment in a sample of 26 .<br><br>Findings include:<br><br>On 09/30/24 at 11:45 AM, the shower room on the west side of the building had mold at the right side of the shower stall between the floor and the wall and along the wall for approximately 8 tiles and between the back wall and the floor for approximately 4 tiles across and 3 tiles up. Each tile appeared to be approximately 4 inches x 4 inches. The attached toilet room had approximately 0.75 inch of black accumulation of dirt and debris around the bottom of the toilet.<br><br>On 10/02/24 at 12:10 PM, V13 (Activities Director/Certified Nurse Aide) stated the shower stall could be cleaner but it is challenging because she does not believe the vent in the bathroom works and they have to keep the hot water on constantly so they have hot water in the shower and they shower all the residents on the west side in the shower room. This is the only shower room on this side of the building.<br><br>On 10/02/24 at 12:32 PM, V15 (Maintenance) stated they are getting an accumulation of black stuff in the caulk and in the grout in the shower stall. They have to keep the hot water running constantly in the shower stall and the attached bathroom because the pump does not work. The vent in the shower room does not work so it is always warm and damp in there. The previous owner knew and they would not fix it. They have done the best they could with it.<br><br>The undated facility policy titled, Physical Plant & Environmental Policy & Guidelines documents in part: the building and grounds must be maintained in the best presentable state and must be done so through routine maintenance and upkeep, housekeeping, and ensuring compliance with current federal, state, local and NFPA (The National Fire Protection Association) codes.<br><br>The census dated 09/27/24 documents 20 residents (R7, R8, R9, R10, R11, R12, R13, R14, R15, R16, R17, R18, R19, R20, R21, R22, R23, R24, R25, R26) reside on the west side of the facility and a total of 47 residents reside at the facility. |

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 - 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** 41610<br><br>Based on interview and record review the facility failed to prevent resident to resident abuse for 1 (R2) of 3 residents reviewed for abuse in a sample of 26. This failure resulted in R2 being pushed down and verbally threatened by R1 and R2 being fearful of R1.<br><br>Findings include:<br><br>R1's Admission Record documents and admitted [DATE] with diagnoses including: dementia with unspecified severity with agitation. R1's New Admission Information Sheet documents a diagnosis of Dementia with Behavior. R1's Diagnosis Sheet (undated) documents a diagnosis of: dementia with aggressive behavior.<br><br>R1's care plan documents a focus area of: the resident (R1) has potential to be physically aggressive to staff and other residents r/t (related to) dementia with a revision date of 07/18/24. The interventions listed include: administer medications as ordered; monitor/document for side effects and effectiveness; analyze times of day, places, circumstances, triggers, and what de-escalate behavior and document; assess and address for contributing sensory deficits; assess and anticipate resident's needs: food, thirst, toileting needs, comfort level, body positioning, pain and etc. (et cetera); communication: provide physical and verbal cues to alleviate anxiety, give positive feedback, assist verbalization of source of agitation; assist to set goals for more pleasant behavior; encourage seeking out of staff member when agitated; give the resident as many choices as possible about care and activities; monitor/document/report PRN (as needed) any s/sx (signs or symptoms) of resident posing danger to self and others; psychiatric/psychogeriatric consult as indicated; and when the resident becomes agitated: intervene before agitation escalates, guide away from source of distress, engage calmly in conversation, if response is aggressive, staff to walk calmly away and approach later. All interventions are dated 06/27/2024.<br><br>R1's Minimum Data Set (MDS) dated [DATE] documents a Brief Interview for Mental Status (BIMS) score of 02, indicating R1 has severe cognitive impairment. Section E, Behaviors, under Behavioral Symptoms documents that physical behavior symptoms directed towards others occurred 1 to 3 days during the assessment period.<br><br>R1's Behavior Tracking Record dated September 2024 documents target behaviors of agitation and aggression. A 0 is documented on all days through 9/26/24, including 9/24/24, indicating R1 had no behaviors.<br><br>R1's Nurse's Notes dated 09/24/24 at 6:45 AM documents: resident was involved with peer on peer with other resident. This resident was the aggressor. (R1) pushed other resident, hit her and knocked her down to the floor and stated, I'm going to kill you.<br><br>R1's Nurse's Notes dated 09/24/24 at 6:55 AM documents: spoke with (psychiatric office) new order to send resident to ER (emergency room ) for psychiatric evaluation.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | R1's Emergency Department Notes from the local hospital dated 09/24/24 documents a Chief Complaint of Aggressive Behavior. A provider notes dated 9/24/24 at 7:50 AM documents presents to ED (Emergency Department) from (name of facility) for aggressive behaviors. Calm and docile for EMS (Emergency Medical Services). NH (Nursing Home) reports he had an altercation with a female resident in the facility.<br><br>R2's Physician Order Sheet dated 09/01/24 to 09/30/24 documents a diagnosis of dementia dated 12/09/23. R2's MDS dated [DATE] documents a BIMS score of 03, indicating R2 has severe cognitive impairment.<br><br>R2's Nurse's Notes dated 09/24/24 at 6:45 AM document: CNA (Certified Nurse Aide) yelling from dining room, this writer (V4-Registered Nurse) ran to the dining room to find resident on the floor with another resident standing up. CNA stated he hit her and pushed her over. Housekeeping saw resident go down and wrote a statement. Resident peer stated I'm going to kill you when resident went down she fell on her right side - arm, elbow, hip and face.<br><br>R2's ED (Emergency Department) nurse timeline notes from the local hospital dated 09/24/24 at 8:20 AM documents: patient presents with right arm/leg pain after another resident pushed her down. At 8:50 AM the notes document: slight grimace with movement of right knee and right elbow. R2's Hospital notes dated 09/24/24 documents: final diagnoses: contusion of right elbow; unspecified dementia, unspecified severity without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety; pain in right knee; headache; and cervicalgia.<br><br>On 09/27/24 at 8:40 AM, R2 stated she was scared. When asked why, R2 stated because of the fight. R2 then stated, that man, he's mean.<br><br>On 09/27/24 at 10:12 AM, V4 (Registered Nurse) stated that R1 can be nice and then all of the sudden something can agitate him and he can become aggressive. She was working when the peer to peer incident happened between R1 and R2. V23 (Housekeeping) witnessed the event and yelled for assistance. She made the report, assessed the residents and sent them out for evaluation.<br><br>On 10/01/24 at 2:10 PM, V18 (Certified Nurse Aide) stated she saw R2 later in the day on 09/24/24 after she returned from the hospital. V18 stated that R2 could not specify where she was hurting but she was trying to tell her about the incident.<br><br>On 10/01/24 at 1:45 PM, V23 (Housekeeping) stated that she was in the hall cleaning looking in the dining room when the incident between R1 and R2 happened. R1 and R2 were sitting at the same table when R1 got up abruptly and went over to R2. R2 stood up from her chair and R1 started yelling at R2. R1 then hit R2 and pushed R2 down. She ran over to them to try to keep R2 from hitting her head and yelled for help at the same time. There was no other staff in the dining room, the nurse on duty was at the nurse's station and the CNA's were assisting other residents. V23 stated, R2 was scared and complained her arm and leg were hurting.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | A final investigation report received by the Illinois Department of Public Health from the facility from V1 (Administrator) on 9/27/24 documents On 9/24/24 at approximately 6:50 AM, it was reported to this administration by (V3-Assistant Director of Nursing) that an alleged peer to peer incident happened between (R2) and (R1). The report further documents that (V23-Housekeeper) stated that she was in the dining room and looked up to see (R1) standing from his seat and he began to yell towards (R2). (R2) then stood from her chair and (R1) moved towards her and pushed her to the floor while telling (R2) that he wanted to kill her. (R2) then said that she was scared. The report concludes the facility can substantiate that no injuries occurred following the interaction between (R2) and (R1).<br><br>The facility policy, dated 11/28/16, titled Abuse Policy and Procedures documents in part: this facility affirms the right of our residents to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined below. This includes, but is not limited to, freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident ' s medical symptoms. This facility therefore prohibits mistreatment, exploitation, neglect 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, exploitation, neglect or abuse of our residents. This will be done by: dementia management and resident abuse prevention. |