| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145850 | A. Building<br>B. Wing | 08/24/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| City View Multicare Center | 5825 West Cermak Road<br>Cicero, IL 60804 |

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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** 39340<br><br>Based on interview and record review, the facility failed to prevent a cognitively impaired resident (R2) from being coerced by another resident (R3) to perform an oral sexual act on him, failed to prevent a female resident (R11) from being inappropriately touched by a male resident (R12) and failed to prevent a resident (R6) from being physically and mentally abused by facility's security staff members (V38, V39), as outlined in the facility's abuse policy. This applies to 3 of 6 residents (R2, R6, R11) reviewed for abuse.<br><br>As a result, R2 was allowed to engage in a sexual act without knowing the consequence of her actions, R11 was forced to experience a violation of her personal space and body and R6 was pushed, threatened and subjected to the use of inappropriate language.<br><br>Findings include:<br><br>R2 had the diagnoses of Schizophrenia, Schizoaffective, and Psychosis. R2's Brief Interview for Mental Status (BIMS) dated 7/3/21 documents a score of five which indicates severe cognitive impairment.<br><br>R2's Care plan dated 7/16/21 documents: R2 demonstrated cognitive impairment related to mental illness.<br><br>Nursing note dated 7/3/21 documents: Approximately 9:45pm, R2 was observed in room with a co-resident. R2's face was toward R3's private area.<br><br>On 8/4/21 at 1:15pm, R2 who was assessed to be confused and unable to report, or even answer questions about the incident dated 7/3/21.<br><br>On 8/6/21 at 2:14pm: V4 (Social Service Assistant) stated, R2 is confused and cannot make her own decisions.<br><br>On 8/10/21 at 12:13am, V1 (Administrator) said, V5 (Certified Nurse Aide/CNA) walked into R2's room, observed R2 looking at R3's private area. I spoke with R3 who stated, R2 performed oral sex on R3. We substantiated the allegation of abuse.<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 8/13/21 at 1:31pm, V51 (PRSC) said, R2 is not able to make decision for herself. R2 is not able to give consent for sexual activities nor would I call R2's family for consent for R2 to have sex.<br><br>A BIMS score determines the cognitive level of a resident. A BIMS score of 00 -07 requires full assistance with decision making. The decision making is done by the Power of Attorney (POA)/Guardian.<br><br>Facility reportable incident sent to IDPH dated 7/3/21 documents: R2 was observed in the room with R3 with face towards R3's private area.<br><br>Hospital paperwork dated 7/3/21 document: R2 was discharged to the hospital for inappropriately touching a male resident.<br><br>R3 had a diagnosis of Schizophrenia and Bipolar. Brief Interview for Mental Status dated 6/8/21 documents a score of fifteen which indicates cognitively intact. Care plan dated 7/20/21 documents: R3 exhibits sexually inappropriate behaviors manifested by attempting to take advantage of peers who lack ability to consent. R3 who was observed and assessed to be alert to person, place and time during the investigation.<br><br>On 8/3/21 at 11:56am, R3 said, I put my penis in R2's mouth. It was consensual. R2 performed oral sex on me.<br><br>Transfer form dated 7/3/21 documents: Behavior- R3 touched co-resident inappropriately, placed on 1:1, R3 sent to hospital for evaluation.<br><br>Hospital paperwork dated 7/4/21 documents: R3 was sent to the hospital for inappropriately touching another female resident.<br><br>Police report dated 7/15/21 documents: R3 admitted to allegedly having sexual contact with a co-resident (R2) on 7/3/21.<br><br>Reportable Incident dated 7/3/21: Addendum 7/15/21: R3 reported that he had allegedly had a consensual sexual relationship with R2.<br><br>R11 was admitted to facility on 2/12/21 with a diagnosis of Schizoaffective Disorder, Bipolar Disorder, Hypertension, and Anemia.<br><br>R11's Brief Interview for Mental Status dated 7/29/21 documents a score of 15/15 which indicates cognitively intact.<br><br>R11's progress note dated 7/13/21 documents: R11 was in the dining area wiping off tables when she was touched inappropriately by a peer.<br><br>On 8/3/21 at 11:10 am, R11 who was alert and oriented at time of interview said, a male resident touched her buttocks while she was in the dining room. R11 said anyone that touched her inappropriately without her consent is in violation of her personal space.<br><br>On 8/4/21 at 2:40pm, V17 (Psych Tech) said, he witnessed R11 in common dining room and R12 touched her buttocks. V17 said he separated the residents and informed 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 | Facility's final abuse report dated 7/18/21 documents under conclusion: It was reported R12 allegedly touched R11 in an inappropriate manner. R12 stated he did not want to talk about it. R11 stated R12 tapped her on the behind as he was walking past. Staff that was present also stated that he tapped her as he was walking past R11 and R12 was redirected immediately.<br><br>Under witness statement for R12 documents: R12 stated he doesn't know why he touched R11's behind when walking past her. R12 said he was very sorry.<br><br>R12 was admitted to facility on 4/14/21 with a diagnosis of Schizophrenia, Hypertension, and Lack of Coordination.<br><br>R12's Brief Interview for Mental Status dated 7/28/21 documents a score of 15/15 which indicates cognitively intact.<br><br>R12's progress note dated 7/13/21 documents: R12 was observed by staff touching female peer on buttocks in dining room. Per R12 I need some p****. Resident separated for safety.<br><br>On 8/3/21 at 4:01pm, R12 who was alert and oriented to self, said he grabbed a resident's butt on the 4th floor, and she slapped him. R12 refused to give any further details.<br><br>On 8/4/21 at 2:40pm, V17 (Psych Tech) said he witnessed R11 in common dining room and R12 touched her buttocks. V17 said he separated the residents and informed nurse.<br><br>R12's local hospital record dated 7/13/21 documents under patient notes: When asked why R12 was sent to the hospital, R12 stated I touched other patients butt and I regret what I did. I did not know why I did it.<br><br>Facility's final abuse report dated 7/18/21 documents under conclusion: It was reported R12 allegedly touched R11 in an appropriate manner. R12 stated he did not want to talk about it.<br><br>R11 stated R12 tapped her on the behind as he was walking past. Staff that was present also stated that he tapped her as he was walking past R11 and that R12 was redirected immediately. Under witness statement for R12 documents: R12 stated, he doesn't k now why he touched R11's behind when walking past her. R12 said, he was very sorry.<br><br>R6 was admitted to the facility with the diagnosis of Schizophrenia. Minimal Data Set (MDS) dated [DATE] Brief Interview for Mental Status documents a score of thirteen which indicated cognitively intact. Nursing note dated 7/27/21 documents: R6 alleged he was verbally abused in the elevator by staff. R6 reported staff used swear words at him.<br><br>On 7/30/21 at 2:37pm, R6 who was assessed to be alert to person, place and time said, I was getting on the elevator, when V39 (Security) pushed me and said, get your as* off the elevator. V38 (Security) stepped off the elevator and said, Nigg** I'm going to beat your as*. We stood in a fighting stance face to face.<br><br>On 8/10/21 at 12:13pm, V1 (Administrator) said, V38 was terminated for verbal abuse toward R6.<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 8/17/21 at 2:26pm, V39 (Security) said, I did not speak inappropriately to R6. V38 (Security) got off the elevator and told, R6 he would whip his as*. V38 (Security) stood face to face with R6 in a fight stance.<br><br>Final reportable incident dated 7/27/21 documents: V38 and V39 spoke inappropriately to R6. R6 was concerned with V38 who appeared to be aggressive. V39 said, V38 spoke inappropriately to R6. V39 was allowed to return to work and will be assigned to a different floor than R6. V38 will not be returning to the facility.<br><br>Employee Disciplinary Action Form dated 8/3/21 documents: V38 (Security) failed to follow employee handbook category 1 number 1 stating resident abuse (verbal or physical) for incident that happened on 7/27/21. Employee will be terminated without any privileges to be rehired. Employee handbook documents: Category 1 offenses are most serious and subject to the employee's immediate discharge without rehire privileges. The following are category 1 offenses: #1. Resident abuse (verbal or physical). V38 was unable to be reached during this survey.<br><br>Facility policy titled Abuse prevention program revised 9/17/21 documents: It is the policy of this facility to prohibit and prevent resident abuse, neglect, exploitation, mistreatment and misappropriation of resident property and a crime against a resident in the facility. Abuse: The willful infliction of injury. Unreasonable confinement, intimidation or punishment with resulting physical harm or pain or mental anguish or deprivation by an individual of goods or services that are necessary to attain or maintain physical, mental psychosocial well-being. Verbal Abuse: any use of oral, written or gestured language that included disparaging and derogatory terms to resident or their families, or within their hearing distance, to describe residents, regardless of their age, ability to comprehend or disability. |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39340<br><br>Based on observation, interview and record review, the facility failed to monitor and supervise residents to prevent unsupervised smoking in the building and to prevent contraband smoking materials from coming into the facility (R8, R23), failed to provide a safe environment by leaving electrical wires exposed and maintain safe electrical outlets in resident's room (R27, R28, R29, R30, R32, R33, R34, R35, R36, R37), and allowed residents to put foil into electrical outlets to ignite a spark to light smoking materials (R8, R23, R31).<br><br>On 8/12/21 this was identified as an immediate jeopardy situation that began on 08/03/21 and was removed on 08/20/21. V1 (Administrator) was informed of the immediate jeopardy on 08/12/21. The immediacy was removed on 08/20/21, but the deficiency remains at a level 2 harm, until the facility can evaluate the effectiveness of the interventions implemented.<br><br>Findings include:<br><br>R8 was admitted on [DATE] with a diagnosis of Schizophrenia.<br><br>R8's progress note dated 7/12/21 documents: resident noted with broken electric cables attempting to ignite fire to light a cigarette butt.<br><br>R8's progress note dated 7/26/21 documents: using improvised devices to light fire in the bedroom, danger to self and others. Transferred to hospital.<br><br>R8's petition dated 7/26/21 documents: using electrical cables to set fire in the bedroom.<br><br>R8's hospital record dated 7/26/21 documents: R8 stated, I was trying to use the electrical cords to light toilet paper so I can smoke weed and crack. Hospital record dated 7/27/21 documents positive finding of cannabis.<br><br>On 7/26/21, R8 said he was trying to light a cigarette by using the electrical wires from the over the bed light in his room. R8 said he removed the wires but was unable to describe how he removed the wires. R8 said he put the wires into the electrical outlet and had toilet paper near the outlet to catch fire to light his cigarette. R8 said he had a cigarette from a previous smoke break. R8 then demonstrated how he lit the cigarette, R8 sat on the floor near the electrical outlet and pulled the privacy curtain near the outlet. R8 put his face near the outlet to catch the flame. R8 said this time the privacy curtain was too close to the outlet and was set on fire. R8 had to put it out with his hands and wet towel.<br><br>On 8/10/21 at 3:21pm, R8 said he called a suppler (R8 refused to give name or description) who would meet him in the common outside patio, where he would receive marijuana. R8 said he would return into the building and was never searched or questioned.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | On 8/3/21 at 3:30pm, R8's previous room was observed with black soot around one outlet. The electrical outlet was observed with an object sticking out which was confirmed by V11 (Maintenance Director) to be a piece of foil. V11 and V35(Maintenance) said they were unaware of any concerns related to the electrical outlets in R8's room but residents in the building will stick things in the outlets to ignite a spark so they can light a cigarette<br><br>R8's smoking assessment dated [DATE] documents: May not be capable of handling/carrying any smoking materials and requires supervision when smoking.<br><br>R23 was admitted on [DATE] with a diagnosis of Schizoaffective Disorder, Bipolar, and Asthma.<br><br>R23's smoking assessment dated [DATE] documents: May not be capable of handling/carrying any smoking materials and requires supervision when smoking.<br><br>R23's care plan dated 12/24/20 documents: R23 as an identified offender with history of aggravated arson 1996 and considered high risk.<br><br>R23's progress notes dated 7/26/21 and 7/27/21 document had no unsafe use of electrical wire by V37(Nurse). R23's progress note dated 8/8/21: R23 using cables to light cigarettes in R29-30's room.<br><br>On 8/10/21 at 4:30pm, V37 said R23 was in the room when the incident with R8 happened on 7/26/21, but was unable to provide any other information related to incident. R23 was unable to provide any additional information about incidents and denied any involvement.<br><br>On 8/5/21 at 4:45pm, R23's room was observed with black soot around one outlet in the room. The hospital bed in the room was observed with cord that had been cut with exposed wires.<br><br>V11(Maintenance Director) said the outlet had black soot around it which indicates that something was placed in the outlet causing a spark. V36 (Maintenance) said that this behavior is happening all over the building and residents are using foil from food deliveries to stick in the outlets to light cigarettes.<br><br>On 8/6/21 at 12:34 pm, R27-28 room had two over the bed light frames on the wall. Within the frame of the lightening device there were two electrical outlet plugs that had black soot on them.<br><br>At 12:44pm, R29-R30's room was observed with two exposed wires from the over the bed the light and one electrical outlet with black soot.<br><br>At 12:51pm, R31's room had one outlet with black soot and small piece of foil, observed along with exposed wires from the over the bed light. At 1:06pm, V11 confirmed that it was a piece of foil in the outlet in R31's room.<br><br>At 1:12pm, R35's room had exposed wires from one of the over the bed lights.<br><br>At 1:14pm. R32-33's room had paper stuffed into the electrical outlet and exposed wires from one of the over the bed lights.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | At 1:15pm, R34's room was observed with four exposed wires from the over the bed light and one electrical outlet with black soot.<br><br>At 1:20pm, R36-37 had two exposed wires from the over the bed lights.<br><br>On 8/10/21 at 2:04pm, R29-30's room had an outlet blackened with soot with a small object within the outlet.<br><br>On 8/19/21 10:50am, R27-R28's room was observed with soot covered outlets and two lightening fixtures over the bed which had been previously observed on 8/6/21.<br><br>At 11:02am R29-R30's room had new observations of foil and an unknown object protruding from one ceiling outlet.<br><br>On 8/5/21 at 1:47pm, V11 (Maintenance) said he has been at facility for about 2 months. V11 said about a month ago residents removed fire lights in a bathroom on the 5th floor. V11 stated staff do not report when these incidents occur. Maintenance staff will find outlets burnt or cut electrical cords from televisions or over the bed lights randomly.<br><br>V11 said they do not do any daily inspections because there is not enough staff. V11 said he has replaced about 20 outlet covers in 2 months but unable to provide any record of replacements or where they were replaced.<br><br>On 8/10/21 at 10:00am, V11 said he was aware that there was a concern related to residents placing cords/foil in the outlets.<br><br>V11 stated there is a possibility of fire if the breaker does not cut the power supply to the outlet. It is possible to get an electrical shock from the outlet if placing objects into the wall but V11 states he has not seen or heard of anyone getting hurt. V11 said they have not done any audits of the rooms but claimed to be placing wall plates over the outlets since June. When asked what rooms they were placed in, V11 was unable to recall specific rooms, unable to produce a log of replacements or receipts of purchases of items. V11 said he has replaced a cover on 8/6/21 on the seventh floor.<br><br>On 8/10/21 at 10:25am, V35(Maintenance) said he has not placed any wall plates on outlets but replaced the outlet cover in R29's room on 8/3/21.<br><br>On 8/10/21 at 10:34am, V36(Maintenance) said he has only placed one wall cover on 8th floor.<br><br>On 8/11/21 at 204PM, V55 (Electrician) said he has never heard of foil being placed in outlets not sure what will happen.<br><br>If there are observations of blackened areas around the outlet, it indicates there was some kind of fire near the outlet. In most cases the circuit breaker will trigger which will turn off the power supply to prevent fires or electrocution but there is always a chance that someone could be injured.<br><br>Facility policy titled: Physical plant weekly inspections undated documents under electrical inspections: All receptacles and switches shall be inspected for cracks, condition of cover plates and any signs of shorts.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | 8/6/21 at 2:14pm, V4(APRSD) said all smoking materials are held by staff and no resident is allowed to smoke independently.<br><br>Facility policy titled smoking policy undated documents: There will be no smoking permitted inside the facility. All resident smoking material will be kept by the facility in a secure location. All smoking remnants will be discarded into approved receptacle by staff or under staff supervision. Residents will have no smoking materials in their possession.<br><br>Facility policy titled Search and Confiscation Policy undated documents: The facility has right to search belongings and person if there is reasonable suspicion that contraband is being brought into the facility. Items that are considered harmful or unsafe for the resident will be destroyed. Prohibited items include but not restricted to the following list: cigarettes, cigars, loose tobacco, lighters, sharps, razors, scissors, knifes or items considered a possible danger.<br><br>On 08/19/21 the surveyors verified by observations, record review and interview that the facility implemented the following to remove the immediacy:<br><br>A Resident who has a history of behaviors that may potential place themselves or others at risk by placing items electrical outlets for the purpose of starting fires to ignite contraband will have interventions put in place to prevent these behaviors. Social Service will conduct a smoking risk review of those residents in the facility that are smokers.<br><br>Psychiatrist/Psychologist/ Psychiatric Nurse Practitioner (NP) will assess resident R8 and R23 to determine if the resident can be managed safely in the facility. Resident R23 was sent to the hospital relating to behaviors on 8/13/21 and remains in the hospital at this time. Resident R8 has been evaluated by Psychiatric NP on 8/13/21. One to One monitoring will remain in place for R8 and R23 until they are determined to no longer be a threat to themselves or others.<br><br>The IDT (Interdisciplinary Team) members which includes Administrator, DON (Director of Nursing) ADON (Assistant Director of Nursing), NP (Nurse Practitioner), PCP, Psychiatrist and Social Service Team determine when one to one monitoring can be decreased, or hospitalization is required.<br><br>On 8/24/21 the surveyor verified by observation, record review and interview that the facility implemented the following to remove the immediacy:<br><br>The system revisions initiated on 8/12/21:<br><br>Residents that are smokers in the facility will have a smoking risk review completed by the social service team under the guidance and assistance of the social service consultant. This will be completed by the Social Service Team members.<br><br>The smoking risk assessment has been initiated immediately today 8/12/21 and will be completed by 8/13/21.<br><br>R8 and R23 have had a care plan revision and interventions put in place on 8/12/2021. The facility instituted one to one to for R8 and R23 until residents have been assessed to no longer display these maladaptive behaviors and if unable to maintain their safety or others safety they will be assessed if hospitalization is appropriate.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | There have been 5 other residents identified that have displayed the maladaptive behaviors of using wires to light their contraband. The residents that display this maladaptive behavior have been placed in 2 designated rooms with group supervision. They are being overseen by the psychological team to monitor and address the behavior.<br><br>The 7 residents identified will meet with Social Service and the Administrator to review the Smoking Policy and Smoking Contract.<br><br>Maintenance Director has replaced outlets to 20-amp Tamper resistant Outlets for the rooms that R8 and R23 are located.<br><br>The facility will continue to replace the outlets on the 7th floor which has higher risk behavioral residents. The 7th floor audit of the sockets and exposed wires was completed on 7/28/21. The number of sockets that have been replaced are 29 as of 8/13/21. The Maintenance Department is currently completing an entire facility audit to assess for any further socket's requiring replacement and light fixtures with exposed wires. This audit will continue until [DATE].<br><br>All the fixtures and sockets in the rooms are being evaluated as well and replaced with tamper<br><br>resistant outlets.<br><br>The striping or removing the wires has not been identified yet for those residents displaying this behavior as they are unwilling to cooperate with the investigation. A few residents are utilizing their teeth as seen with marks on plastic coating and no one has indicated what else they are using. The residents also refuse to indicate how the wires are stripped.<br><br>All nursing staff which includes Licensed Nurses, Registered Nurses, Certified Nursing Assistants and other facility staff such as: Social Service Team members, Escorts, Psych Techs, Security, Resident Assistants, Activity Aides, Smoke Monitors, Administrators and Assistant Administrators will be in serviced on one-to-one policy by the Regional Nurse Consultant, DON, and ADON. In-service on one-to-one policy began 7/29/21 and will be completed by 7/30/21.Staff that are not able to attend in person in-service will be in-serviced via phone and next day return to work will sign off on the in-service.<br><br>Newly hired employees will be trained on One-to-One policy and CPI registration as part of new employee training. Evaluation on understanding of One to One see attached quiz<br><br>The entire team as listed above is responsible for assisting with providing one to one understanding the process of why a one to one may be required for some residents. The team members are also responsible for identifying behaviors that residents maybe displaying and bringing it to the attention of an IDT member.<br><br>Behavioral programming will include the following with emphasis on maladaptive behaviors relating to safety.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | The resident has a psychiatric diagnosis (es) and may benefit from skills training. The resident requires attention in the priority skill areas: Symptom management - symptom monitoring, increased self-knowledge, self-awareness, understanding personal stressors, coping strategies, stress management, impulse control, medication management, self-medication, and relapse prevention.<br><br>The resident will engage in skills training behavior as evidenced by participation in supportive group programming via groups, 1:1 licensed therapeutic counseling, psychiatric follow up and compliance with medication regimen inventions to be implemented<br><br>1. Conduct an appropriate skill needs/level of functioning.<br><br>2. Teach skill development addressing socially inappropriate and/or maladaptive/ disruptive via group and/or individual formats (i.e.: licensed counselor and psychiatrist) on a routine, schedule frequency.<br><br>3. Use skill generalization techniques in which new skills are introduced gradually, explained clearly and participants are enabled to practice each skill.<br><br>4. Intervene when I am observed to display any inappropriate behavior. Communicate that I am responsible for exercising control over my own impulses and behavior (Social Skills training).<br><br>5. As warranted conduct: Random room safety checks, personal wellness check, mouth check during medication pass, behavior monitoring, evaluation of mental status, mood state and thought content.<br><br>6. Provide me with initial psychiatric management to monitor my psycho-active medications, provide support and enhance structure. Inform my psychiatrist of progress, stabilization, or regression.<br><br>These group and individual programs will be conducted by the outside psychologist group and in-house social service team.<br><br>Newest updates from 8/19/21: Updates specific to the Outlets.<br><br>The RDO (Regional Director of Operations) has created the floor plan grid specific to all outlets in the rooms corridor and is systematically checking off on floor plan what outlets have been completed.<br><br>The priority floor is the 7th floor where residents with these behaviors are currently located.<br><br>There is a specific employee who is designated to being responsible for assigning the one-to-one monitors or group monitor for the facility. There has been a Monitoring Tech Job Description created which staff assigned to this position will be educated on the expectations of the job.<br><br>Newest Updates from 8/24/21: Updates specific to the entire 7th floor and 5th floor<br><br>The light sockets that were identified on 8/19/21 identified to be obstructed with debris was removed on 8/19/21.<br><br>The 7th floor sockets have been replaced and/or covered with plate covers as 8/20/21<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | All outlets on the 7th floor unit have been secured. Residents noted with the maladaptive behaviors have been identified and have been placed on group monitoring, this was completed on 8/20/21.<br><br>41758<br><br>Based on observation, interview, and record review the facility failed to have an effective 1:1 monitoring system in place, failed to implement their crisis prevention intervention protocol to de-escalate an incident of self-injurious behavior for 1 of 1 residents (R1) reviewed for supervision. This failure resulted in R1 being able to pry off a heating vent and stabbing herself in the abdomen while under 1:1 supervision by facility staff and R1 to being sent to the local hospital for treatment.<br><br>On 7/28/2021 this was identified as an immediate jeopardy situation that began on 07/14/21 and was removed on 07/30/21. V1 (Administrator) was informed of the immediate jeopardy on 07/28/21.<br><br>The immediacy was removed on 07/30/21, but the deficiency remains at a level 2 harm, until the facility can evaluation the effectiveness of the interventions implemented.<br><br>Findings include:<br><br>R1 admitted to facility on 5/12/21 with diagnoses of Schizoaffective Disorder, Major Depressive Disorder, Schizophrenia, Unspecified Psychosis, Paranoid Personality, Delusional Disorder, Auditory Hallucinations, and Post Traumatic Disorder.<br><br>R1's plan of care dated 6/12/2021 shows R1 has a history of self-harmful & self-mutilation ideation (thoughts) and/or behavior.<br><br>R1's interventions dated 6/7/21 include: As warranted, conduct, random room safety checks, personal wellness checks, and behavior monitoring of resident. Interventions dated 5/21/21 include conduct appropriate assessments upon admission. Review transfer record, including screening to determine any history of self-harm; encourage resident to seek help of staff when in distress.<br><br>Facility incident report dated 5/21/2021 documents: An incident occurred in R1's room, R1 admitted to stabbing herself with a pen. A complete body assessment revealed pen stuck in resident stomach. 911 called. No witnesses found.<br><br>Facility incident report dated 6/4/2021 documents: An incident happened in R1's room. R1 observed with open area to abdomen and small amount of bleeding noted. R1 had broken pieces of pencil in her hand. R1 stated she stuck a pencil in her stomach.<br><br>Facility incident report dated 6/17/2021 documents: An incident occurred in R1's room, call to room by CNA, R1 stated she swallowed a key. No witnesses.<br><br>Facility incident report dated 6/30/2021 at 12:54 AM documents: An incident occurred in R1's room. R1 was noted with self-inflicted skin tears on left wrist and lower abdomen with plastic spoon. R1 stated, I do not want to be here, just take me to the hospital.911 called. No witnesses found.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | Progress note dated 7/14/21 documents: R1 was readmitted to the facility from local hospital around 1:00PM.<br><br>Progress notes dated 7/14/2021 at 17:32 documents: V8 Nurse was doing petition to send R1 to hospital. R1 stated she was giving V8 ten minutes to get R1 out of the building. I sent V5 (CNA) to closely monitor. V5 (CNA), yelled for (V8) to come to R1's room. V8 observed blood coming from R1's abdomen. R1 had a sharp object in her hand. V8 stated I tried to get R1 to give me the object, R1 tried to cut me with the object. I called security to get the object.<br><br>A facility incident report dated 7/14/2021 documents: At 4:45pm, V8 was preparing petition to send R1 to the hospital, V5 (CNA-Certified Nursing Assistant) placed at room to closely monitor R1.<br><br>Witness statement from V5 documents: R1 grabbed a sharp object when I tried to take the object R1 started to cut at me with it. Then R1 took the object and cut her stomach. Witness statement from V8 documents: Observed R1 with blood coming from her stomach. R1 had a sharp object when I tried to take it from her, the resident tried to cut me with it and said she will cut my throat with it.<br><br>On 7/20/21 at 5:04p.m. V5 said she was told by the nurse that R1 needed 1 to 1 monitoring, V5 said, she was in the room standing behind R1 when R1 pulled the vent off the radiator in the room, R1 then turned to V5 and began to wave the object in front of V5 face while saying I will cut you. V5 said, she yelled out for help and was asking R1 to put the object down and or give her the object. V5 said, R1 did not give her the object but then took the object and cut herself in the abdomen area. V5 said, R1 then dropped the object. V5 said, the nurse arrived and stayed with R1 while she went to call a code gray. V5 said, R1 needed 1 to 1 observation because R1 harmed herself in the past, by swallowing a key and cutting herself with a plastic spoon.<br><br>On 7/21/2021 at 1:28PM, V5 said, when she was monitoring R1, R1 walked to the nurse station, R1 stated, to V8 you have 10 minutes, V5 said, she did not know what R1 was talking about. V5 said, V8 told her to watch R1 closely and she continue to follow R1 to her room. V5 said, while in R1's room, V5 was sitting in a chair, she saw R1 standing at the window, R1 was leaning forward a bit. V5 said, she saw R1 hands moving near the radiator vent. V5 said, she stood up and walked toward R1's back, R1 continued to have hand movement while leaning toward the radiator vent. V5 said, she never asked R1 what she was doing, nor did she redirect R1 at that time. V5 said, she heard a click sound and that's when R1 turned around toward V5, R1 had the radiator vent in her hand and began to wave it at V5, while saying I will cut you b####. V5 said, she then asked R1 to put the object down and give it to her (V5). V5 said, R1 then raised her shirt and cut herself in the stomach area. V5 said that's when she yelled for help. V5 said, she did not yell for help prior to R1 cutting herself and she did not call code gray when she saw R1 by the window doing something with her hands When asked if R1 was trying to remove the radiator vent when V5 observed R1 moving her hands near the radiator vent V5 would not respond.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | On 7/20/21 at 1:20PM, V8 said, she arrived at the facility for her shift around 3:00pm on 7/14/2021, as she got on the elevator, V8, R1 and V5 got on with her. V8 said, she was informed by V5 that R1 needed 1 to 1 monitoring, V8 said, once on the 8th floor, she informed V5 to closely monitor R1 when they got off the elevator. V8 said, close monitoring and 1:1 observation is the same thing. V8 said, close monitoring and/ or 1 to 1 observation is when the staff keeps an eye on the resident, the staff can sit outside the room or the staff can go in the room as long as they watch the resident. V8 said, maybe 15 minutes after 3:00pm, R1 and V5 approached the nurses' station and R1 said you have 10 minutes to get me out of here or I will hurt myself V8 stated, she told R1 okay, I'm working on it and you don't have to do that. V8 said, R1 and V5 returned to R1's room. V8 said she does not know if V5 was inside the room with R1 or standing on the outside of the door of R1's room. V8 said, she placed a call to the physician and the physicians plan was to petition R1 for evaluation as she was preparing the involuntary petition. V8 said, about 15 minutes later she heard V5 yelling out for help. V8 said when she went to R1's room, she observed R1 bleeding from the stomach area. V8 said R1 was bleeding bad there was a lot of blood, V8 said, she observed blood on R1's shirt, pants and the floor. V8 said, she saw a horizontal laceration to R1's stomach however she did not complete an assessment of the wound because R1 would not allow her to. V8 said, she then informed V5 to get help, and she heard V5 announce a code gray. V8 said, R1 would not put the sharp object down when she asked R1 to put the object down. V8 said, R1 waved the object in her face stating, I will cut you. V8 said, R1 did not put the sharp object down until the two male staff arrived and that's when R1 handed the object to V12 (Security). V8 said, R1 would not allow anyone from the facility to assess her injuries or render first aide, R1 continued to say do not touch me V8 said, she left the room and called 911. V8 said, the paramedics arrived and put R1 on the stretcher. V8 said, she does not know if the paramedics rendered first aide to R1.<br><br>On 7/20/21 at 1:20PM V8 said, she knew R1 required 1 to 1 monitoring because she was informed of this and also, she used her judgement to determine R1 needed 1 to 1 monitoring because R1 has harmed herself about 3 times when she worked with R1. V8 said, R1 does not want to be in the facility, and she hurts herself when she wants to go back to the hospital. V8 said, she did not call code gray when R1 said, she was going to hurt herself.<br><br>R1's local police report dated 7/14/2021 at 4: 47p.m. documents: Police were dispatched to a call of psychological evaluation at the facility. Local police dispatch advised that a resident cut herself in her stomach with a razor and still had it in her hand. Upon arrival, along with the local paramedics went to the eighth floor where the resident was located standing near security. The resident was identified as R1. V5 devised that R1 had been discharged from hospital on the above date and was admitted to the facility. V5 related that R1 appeared to be distraught upon arrival and aggressive. While in her room, V5 advised that R1 began cutting herself with a razor. V5 provided the said razor, which in fact was an air vent from the room.<br><br>Officer was able to locate the A/C unit in the room with the missing vent. As V5 walked into R1's room, she observed her cutting her lower stomach area and yelled at V5 to leave her alone. The air vent was ultimately removed from R1's hand before the police arrival. V5 further added that R1 has an extensive history of harming herself, as she was said to have swallowed pills, keys, and cut herself in the past. Officer took eight digital photographs of R1's room, the observed blood, air vent used to self-harm and A/C unit with missing vent. The photographs have been attached to the incident report. R1 was transported to local hospital for further medical treatment.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | On 7/20/21 at 5:50PM, the surveyor observed one picture in the police report of the object that R1 used to cut her abdomen. The picture showed a rectangular object which looked like the vent cover that was observed in the facility. The vent cover was noted to have coagulated blood near one corner of the surface which covered approximately a fourth of the vent cover.<br><br>On 7/20/21 at 1:53 PM. while accompanied by V11 (Maintenance Director), the surveyor observed the radiator unit in R1's room listed on the incident report, there was a gray radiator /air conditioner unit noted in front of the window. The unit had 6 vents in place on top of the unit, there was an opening noted to the right of the unit (front facing). V11 said, there was a vent missing from the radiator/ air conditioner unit, V11 said, there's six vents and it should have seven vents on top, also there should be a door where the open area is on the unit.<br><br>R1's Local hospital record dated 7/15/21 documents: R1 was admitted due to self-inflicted stab wound to abdomen with piece of furnace to a previous stab-wound site on abdomen. Under abdomen documents: 8cmx 2 cm x 3cm depth.<br><br>On 7/20/21 at 4:34p.m V3 (Social Service Director) said 1 to 1 observation and close monitoring are two different types of observations. V3 said 1 to 1 observation (monitoring) is used when a resident threatens harm to self or others. V3 said, during 1 to 1 observations staff should be within arm's length of the resident. V3 said the staff should have visual control of the resident, they should be able to see what the resident is doing with their hands, staff must accompany the resident at all times and if the staff need a relief, the staff must wait for coverage, staff should never leave the resident alone. V3 said close monitoring are frequent rounds, staff does not have to stay with the resident at all times. V3 said he does not know how often staff should conduct rounds during close monitoring observations. V3 said staff is trained in CPI (Crisis Prevention Intervention), CPI is a non-violent crisis intervention used to deescalate a situation with a resident. V3 said CPI is used when the resident is past the point of de-escalation, when the resident is physically acting out towards others, when residents try to harm themselves or others. V3 said when a resident says they will hurt themselves, staff should seek help from the Social Worker, the Social Worker will then counsel the resident, and the Social Worker would get the nurse involved to contact the physician for orders. V3 said R1 has known behavior of hurting herself. V3 said R1 required 1 to 1 observation because of her behaviors of self-harm. V3 said he was not there when the incident occurred but what he understands is that R1 was on 1:1 observation when R1 removed an object from the A/C unit in her room and cut her abdomen with the object. V3 said the facility failed R1 during this 1 to 1 observation because R1 cut herself while she was on a 1 to 1 observation. V3 said R1 should not have any sharp objects in her room or in her possession, nor can she have any objects that she can use to inflict harm to herself with. V3 said R1 is a danger to herself and others. On 7/21/21 at 11:19a.m V3 said it is difficult for the facility to conduct an assessment on R1's behaviors, triggers and manage her because R1 usually is discharged shortly after her admissions to the facility. V3 said the 8th floor where R1 resides has not had a social worker for 2 months, V3 said he just acquired that unit along with his assistant. V3 said R1 is managed with 1 to 1 observation. V3 said the facility has given R1 a 30-day notice.<br><br>On 7/20/21 at 12:30PM V4 (Social Service Assistant) said he was informed that R1 cut herself with a sharp object that she removed from the air conditioning unit in her room. V4 said R1 has behaviors of self-harm. V4 said R1 requires 1 to 1 observation at all times because of her behavior of self-harm.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | On 7/20/21 at 3:15p.m V10 (ADON- Assistant Director of Nursing) said the facility does not have a policy for 1 to 1 observation. V10 said, 1 to 1 monitoring/observation are for residents that are at risk for self-harm or harm to others. V10 said when a resident is on 1 to 1 observation the staff should be within arm's length of the resident, the staff should be in eye view of the resident and be able to see what the resident is doing with their hands, V10 said the staff should be able to touch, grab and intervene if something happens. V10 said 1 to 1 observations are conducted to prevent the resident from harming themselves and others. V10 said when V5 saw R1 standing at the window and moving her hands near the radiator vent she would have expected V5 to redirect R1, ask R1 what she was doing and also to redirect/stop what she was doing, V10 said she would not have expected V5 to call a code gray unless R1's behavior was escalating.<br><br>R1's hospital record dated 7/14/21 at 920AM documents under psychiatric progress note history: R1 more towards baseline. She does have 2 sitters because she's very impulsive. Under short term goals dated 7/13/21 documents: Self injury- R1 seems to be injuring herself for strategic purposes that are unrelated to any suicide attempts or gestures. R1 purposely injures herself to this extent. Under 1:1 (monitoring) si [TRUNCATED] |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>39340<br><br>Based on observation, interview and record review, the facility failed to ensure facility staff followed infection control practices/precautions while caring for residents that have tested positive for COVID-19 or PUI (Person Under Investigation) by not having residents wear appropriate PPE (Personal Protective Equipment) and staff not wearing appropriate PPE and performing hand washing, these failures affected 4 of 4 residents (R38, R39, R19 and R22) reviewed for COVID-19 infection precautions.<br><br>Findings include:<br><br>During the survey on 8/5/21 at 5:12pm, observations on red and Yellow Zones performed, V41 (Psych Tech) was observed doing one to one with R39. V41 was wearing a surgical mask with a face shield. V26 (CNA/Certified Nurse Aide) was observed wearing a surgical mask and face shield. R39's physician order sheet dated 7/22/21 documents: Transmission Based Contact/Droplet Isolation. Yellow Zone: For symptomatic, suspected or resident being tested for COVID-19.<br><br>On 8/10/21 at 4:19PM, V2 (DON/ Director of Nursing) said, all staff should be wearing N95 mask with a face shield while on any of the units due to positive cases in the facility.<br><br>On 8/3/21 at 1:16pm, V28 (Nurse) said, R38 and R39 are in the Yellow Zone due to being exposed to COVID-19 positive residents. Staff should be performing hand hygiene before and after entering/exiting resident rooms and in between each resident when providing care.<br><br>On 8/3/21 at 1:06pm V27 (CNA) entered through the plastic barrier entrance to pass R38's lunch tray. V27 took the tray into R38's room, set the tray down on R38's bedside table, exited R38's room without performing hand hygiene then passed a cup of juice to R39.<br><br>On 8/3/21 at 1:20pm, V27 (CNA) said, I did not perform hand hygiene, I forgot.<br><br>On 8/10/21 at 10:49am, V2 (DON) said, handwashing should be performed before and after handing a resident a tray and enter/exiting a resident room.<br><br>R38's physician order sheet dated 8/3/21 documents: Transmission Based Contact/Droplet Isolation. Yellow Zone: For symptomatic, suspected or resident being tested for COVID-19.<br><br>R39's physician order sheet dated 7/22/21 documents: Transmission Based Contact/Droplet Isolation. Yellow Zone: For symptomatic, suspected or resident being tested for COVID-19.<br><br>R19's COVID test results dated 8/3/21 document positive results. R19's physicians order dated 8/3/21 document transmission-based contact/droplet isolation for 14 days.<br><br>R22's COVID test results dated 8/3/21 document positive results. R22's physicians order dated 8/3/21 document transmission-based contact/droplet isolation for 14 days.<br><br>(continued on next page) |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 8/10/21 at 4:01PM, R19 and R22 were observed in surgical masks that were below their noses leaving their rooms and were escorted by V42 (Security) to the common dining area for a smoke break. V42 was observed with no gown or gloves while escorting the residents or during the smoke break in the dining room. Upon exiting the common area, R19 and R22 were observed with surgical mask below their nose. Residents, staff and surveyors were observed in the common hallways used by R19 and R22.<br><br>On 8/10/21 at 4:26PM, V2(DON) said COVID positive residents can smoke in the dining room with supervision. Staff monitoring the COVID residents should be wearing all personal protective equipment to include N95 mask, gown, gloves and face shield. COVID positive residents leaving the red zone should be wearing N95 mask. If a surgical mask is worn it should be worn over the resident's nose and mouth to reduce risk of any transmission.<br><br>On 8/10/21 at 4:09 PM, V42(Security) said he is supposed to wear a gown and gloves when entering the red zone. V42 said he was unsure if he had to wear a gown during smoke break with COVID positive residents.<br><br>Facility policy titled COVID-19 PPE Zones guidelines updated 3/28/21 documents: Red Zone (positive COVID 19); N95 mask, gown, gloves, eye protection, face shield, hair and shoe covering. Yellow Zone suspected or presumed COVID 19 unit: N95 mask.<br><br>IDPH Updated guidance for nursing home and long-term care facilities for COVID-19 dated 8/6/21 documents under outbreak guidance: Staff must wear an N95 respirator and eye protection on all units until there are no new positive cases for 14 days.<br><br>Facility census on 8th floor on 8/10/21 documents 24 residents on the unit.<br><br>COVID-19 Zone Guidelines dated 3/28/21 documents: Yellow Zone- suspected or presumed COVID-19 unit.<br><br>Hand Hygiene Guidelines documents: when hands are visibly soiled, exposed to spores forming organism has been suspected or proven. Hand should be washed with non-microbial or anti-microbial soap. |