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S 000	Initial Comments Annual Certification Survey	S 000		
S9999	Final Observations Licensure Violations: 1) Statement of Licensure Violation: 1 of 1 Violations: 300.610a) 300.1210b) 300.1210d)6) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee and representatives of nursing and other services in the facility. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures: d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These Regulations were not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide adequate supervision to prevent a resident to resident altercation.	S9999		

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This failure resulted in R92 being pushed by another resident, sustaining a right hip fracture that required surgical repair and an extensive hospitalization.
This applies to 1 resident (R92) reviewed for safety and supervision.

1. R92's face sheet shows she was admitted to the facility on 6/20/18 with diagnoses including advanced dementia without behavioral disturbance, muscle weakness, depressive and anxiety disorders, and other symptoms and signs involving appearance and behavior. R92's Minimum Data Set (MDS) assessment of 9/25/18 shows she is cognitively impaired, has behaviors that significantly disrupt care or living environment, and wandering that significantly intrudes on the privacy or activities of others. The MDS shows R92 requires assist of one staff member for transfers and has a history of falls.
On 12/11/18 at 9:28 AM, R92 was sitting in a wheel chair in the hallway outside of her room. A wedge pillow was in between R92's legs. Other than stating her name, R92 was not able to be interviewed. At 11:51 PM, V30 (R92's family member) said R92 had a recent fall in which she was pushed down by another resident. V30 said R92 was in the hospital for several days due to having surgery for a hip fracture she sustained when she was pushed down by the other resident.
R92's fall report of 11/6/18 shows she was pushed by another resident resulting in a fall. R92 was last observed by staff ambulating in the hallway. The report shows R92's right lower extremity was externally rotated and R92's pain scale was determined to be a 10 out of 10 due to R92 screaming and facial grimacing. R92 was sent to the emergency room for evaluation.
The 11/15/18 notes from the local hospital show

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S9999	Continued From page 3 R92 sustained a right femoral neck fracture (hip fracture) and was status post right hip hemi-arthroplasty (hip replacement surgery). The notes show R92 developed a fever due to aspiration pneumonia post surgery. R92's progress notes show she was sent to the hospital for evaluation on 11/6/18 and returned to the facility on 11/16/18. On 12/11/18 at 1:46 PM, V1 Administrator said R23 was the resident who pushed R92 down on 11/6/18. Progress notes of 11/6/18 show "Witnessed by staff. Pushed to floor by another resident...Right lower extremity externally rotated, pain indicated at 10 out of 10 due to screaming and facial grimacing." On 12/13/18 at 11:11 AM, V16 (Environmental Services) said she witnessed R92's fall. V16 said R23 was walking towards the resident rooms and R92 was following R23. V16 said R92 tried to reach out for R23. R23 turned around and pushed R92. V16 said the incident occurred by the entrance to the dining room. V16 said the Nurses were not in the dining room at the time of the incident and a CNA (Certified Nursing Assistant) was behind the Nurse's desk. V16 said no staff were walking with R92 or R23 at the time of the incident. V16 said R23 can be aggressive. She get's agitated and she paces a lot. You can see the agitation in her face. V16 said V11 (Licensed Practical Nurse-LPN) and V12 (Registered Nurse-RN) were working the unit on 11/6/18 when the incident happened. On 12/12/18 at 2:31 PM, V6 (Social Service Assistant Director) said R23 has had behaviors of hitting at staff and other residents. On 12/13/18 at 12:53 PM V11 (RN /dementia unit director) said R23 does not like people touching her. R92 went up and grabbed R23's arm. V11 said she did not see the incident	S9999		

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because she was in the Nurse's room doing paperwork.
On 12/13/18 01:00 PM, V12 LPN said when the incident happened he was in another resident's room doing a treatment and he did not see the incident occur. V12 said R92 has a habit of reaching out to people. R23 does not like to be touched and has a history of pushing other residents and staff. V12 said with R23 you have to be very careful not to invade her personal space. V12 said he came out of the resident's room when he heard a commotion and saw R92 on the floor. V12 said when you have a resident that is aggressive you have to keep a close eye on them.
On 12/13/18 at 1:14 PM, V14 CNA said she was working the shift R23 pushed R92 down. V14 said she did not witness the incident. "I was in the dining room. I just saw (R92) laying on the floor after it happened. (R23) has a history of pushing other residents. If we see another resident walking in the hall when (R23) is there we keep an eye on them. I don't think (R23) likes to be touched." V14 said some residents will walk up to (R23) and try to talk to her but she does not like that. V14 said R92 used to be a CNA and she likes to reach out to other residents like she is helping them. V14 said when a resident has behaviors of hitting and pushing you need to keep a closer eye on them for their safety and for the safety of other residents.
On 12/13/18 at 12:13 PM, V5 (Care Plan Nurse) said after one of R92's previous falls on 6/25/18, the intervention put in place was for staff to stand by and assist with transfers. V5 said R92 should have been a stand by assist since that time.

R92's falls care plan shows on 10/02/18 an intervention of "Use assist of one and a gait belt when ambulating or transferring resident" was

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S9999	Continued From page 5 initiated. R23's Progress notes from 9/7/18 through the present were reviewed showing multiple incidents of agitation, aggression and resident to resident altercations. On 12/13/18 at 2:21 PM, V2 (Director of Nursing-DON) said she could not find a policy and procedure addressing supervision of residents with behaviors. V2 said she would look to see if she could find a policy and procedure regarding protecting other residents when a resident has behaviors. V2 said the only place that the facility has any policy and procedure addressing resident safety is in their Abuse Prevention Program Facility Policy which shows "VI. Protection of Residents. The facility will take steps to prevent potential abuse while the investigation is underway. Residents who allegedly abused another resident will be removed from contact with other residents during the course of the investigation." On 12/14/18 08:19 AM, V2 (DON) said one assist with ambulation means a CNA or a Nurse should be walking with the resident. V2 said when R92 was on the dementia unit (the unit the incident occurred on) she was a one assist. V2 said R92's falls care plan says assist of one and a gait belt when ambulating or transferring resident. "They should have had a gait belt on her whenever she was walking or transferring. Staff should have hands on gait belt to help keep her steady. No staff was walking with (R92) when she was pushed." V2 said if someone had been walking with R92 they could have possibly intervened or redirected her to prevent the incident.	S9999		

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(A)

2) Statement of Licensure Findings:

300.610a)
300.1210b)
300.1210c)3)
300.1220b)3)
300.3240a)

Section 300.610 Resident Care Policies

a) The facility shall have written policies and procedures, governing all services provided by the facility which shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee and representatives of nursing and other services in the facility. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting.

Section 300.1210 General Requirements for Nursing and Personal Care

b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with

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S9999	Continued From page 7 each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures: c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition.	S9999		

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S9999	Continued From page 8 The plan shall be reviewed at least every three months. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These Regulations were not met as evidenced by: Based on observation, interview, and record review, the facility failed to develop individualized interventions for a resident with dementia who exhibits aggressive behaviors. This failure resulted in the resident's aggressive behaviors continuing and causing major injury to another resident. This applies to 1 resident (R23) reviewed for behaviors. The findings include: On December 11, 2018 at 9:15 AM, R23 was ambulating throughout the dementia unit. R23 was seen going into other resident's rooms while the other residents were in the main area and sitting on their beds. R23 was not interviewable. On December 12, 2018, at 1:15 PM, R23 was sitting in the hall area between the resident rooms and the main living area in a chair. R23 would get up from the chair and pace the halls with her hands on her hips while looking into each resident room and then go back and sit down in the chair. On December 13, 2018, at 8:50 AM, R22, R29, and R41 were sitting at the dining table watching down the hallway at R23 who was	S9999		

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pacing the halls. R22 said, "There she goes again. See her down there." R29 said, "There she is, she is the one who pushed me, she just keeps going up and down there just like that."

R23's electronic medical record showed on November 6, 2018, at 1:16 PM an "event" was added for R23 which showed R23 pushed another resident but did not include any detail into the incident other than being aggressive toward others. On December 11, 2018, at 1:46 PM, V1 (Administrator) stated R92 was pushed down by R23 on November 6, 2018. R92's electronic nursing progress notes showed on November 6, 2018 at 1:16 PM, "witnessed by staff pushed to floor by another resident. Nursing staff responded immediately to ensure safety and assess. Resident on floor on back. RLE (right lower extremity) externally rotated, pain indicated at 10/10 due to resident screaming and facial grimacing ..." R92's nursing progress note dated November 6, 2018 at 1:36 PM showed R92 was taken to acute care hospital by ambulance. R92's inpatient progress note summary from the acute care hospital dated November 15, 2018 showed, " ...femoral neck fracture .... Developed fever due to aspiration pneumonia ...family is very involved in care and expressed patient is in intractable pain "

R23's face sheet showed she was admitted to the facility on September 7, 2018 with diagnoses of unspecified dementia with behavioral disturbance and hypertension. R23's MDS (Minimum Data Set dated September 16, 2018 showed R23 exhibiting physical behavioral symptoms directed toward others and verbal behavioral symptoms directed toward others.

R23's electronic nursing progress notes showed

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aggressive behaviors and pacing up and down the halls started shortly after admission. R23's nursing progress note dated September 8, 2018 showed R23 was pacing, running down the hall, hitting staff and at 7:30 AM slapped another resident on the shoulder. R23's nursing progress note dated September 19, 2018 at 7:00 AM showed R23 pushed another resident causing the resident to fall backwards onto the floor. R23's nursing progress note dated September 20, 2018 showed R23 reached out and gave another resident a slight push on her upper arms. R23's nursing progress note dated October 22, 2018 showed R23 hit another resident in the arm. R23's nursing progress note dated October 26, 2018 showed a certified nursing assistant heard something fall to the floor and then saw another resident losing their balance backwards with R23 standing in front of them. The same October 26, 2018 note showed the other resident stated "she pushed me". R23's nursing progress notes did not include an entry for November 6, 2018 when the incident occurred with R92.

R23's behavior monitoring record showed no entries for behaviors which occurred on November 6, 2018. R23's complete current care plan provided by the facility on December 12, 2018 did not include a care plan for resident behaviors. As of December 14, 2018 at 10:00 AM R23's plan of care did not include an individualized, person centered behavior care plan.

On December 14, 2018 at 9:00 AM, V2 DON (Director of Nursing) said R23 was put on a new psychotropic medication on November 7, 2018 in response to the incident that occurred on November 6, 2018. V2 said the facility staff had talked about starting a different medication to try

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and curb some of the anger and aggression R23 was exhibiting. V2 said she did not know if they increased supervision for R23 after the incident on November 6, 2018. Evidence was requested of increased supervision of R23 after she was witnessed pushing another resident to the floor and none was received. V2 said all of the documentation for 15 minute checks for R23 was provided. V2 said R23 has been on 15 minute checks on and off for months now. V2 said they received an order to send R23 out to an acute care psychiatric hospital on November 20, 2018. V2 said she was not made aware of any other incidents with R23 when she pushed any other residents down to the floor. When this surveyor discussed the four previous incidents that occurred with V2 regarding R23 she was surprised to see there had been a previous incident that R23 pushed a resident to the floor.

On December 12, 2018, at 2:50 PM V13 (Activity Aide) said she works on the dementia unit Monday through Friday from 9:00 AM until 5:00 PM. V13 said R23 does not like other people to be up close to her and sometimes she will push people for no reason. V13 said R23 had knocked another resident over on to the floor before the incident with R92. V13 said if a new employee were to come onto the unit they can ask other people who work here information regarding how to take care of the residents and what the residents are like. V13 said the report sheet she uses does not include an area to say if a resident has behaviors and what the behaviors are. V13 said she was on the dementia unit at the time of the November 6, 2018 incident. V13 said she was with a group of residents who were listening to someone play guitar in the main dining area when she heard R92 yelling behind her. V13 said R92 was laying on the floor and R23 went out to the

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hallway and was just looking in the dining area as they were checking on R92. V13 said R23 was not any different after the incident. V13 said before the incident R23 was in the hall wandering just as she has been now. V13 said staff have to keep an extra close eye on R23.

On December 13, 2018, at 1:14 PM, V14 CNA (Certified Nursing Assistant) said she was working the day R23 pushed R92 down. V14 said R23 has a history of pushing other residents. V14 said, "I don't think [R23] likes to be touched. When a resident has behaviors of hitting and pushing you need to keep a closer eye on them for the safety of other residents and the resident with behaviors."

On December 13, 2018, at 2:31 PM, V6 (Social Service Assistant) stated R23 has had behaviors of hitting other residents. V6 said a care plan should have been developed with interventions to deter her behaviors of striking out at other residents. V6 said there was no care plan developed. V6 said staff do track behaviors and document in behavior book and at the end of the month she takes the sheets out and reviews them. V6 said if she needs to at that time she will make an additional note in the resident's progress notes about the behavior.

On December 13, 2018, 3:21 PM, V6 said when residents are having hitting or throwing behaviors they are put on 1:1 supervision. R23's electronic medical record showed no evidence of 1:1 supervision. V6 said she tried to get her into an acute psychiatric hospital on November 20, 2018 when they received the order to send her but they were having trouble with payer source. V6 said we tried four other facilities also but no one would take her. R23's medical record showed no

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STEPHENSON NURSING CENTER	2946 SOUTH WALNUT ROAD FREEPORT, IL 61032

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S9999	Continued From page 13 evidence of multiple attempts at placement into an acute psychiatric setting. V6 said she does not recall what other facilities she tried to call for placement. V6 said she has no notes showing what facilities she contacted. On December 13, 2018 policies were requested regarding dementia care, resident behaviors, 15 minute checks, and 1:1 supervision and V2 stated the facility does not have a policy for these. The only document the facility could provide that addressed residents with aggressive behaviors was provided as an untitled binder that was referred to as a behavior tool. Upon review of the binder page 45 included the behavior "Aggression" with possible interventions to include, "1. Remove resident from area, 2. Remove other residents from area that may be causing situation, 3. Remove anything that causes excess noise levels, 4. Distract resident by singing/dancing ..." (No Violation)	S9999		