STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145937	A. BUILDING _____ B. WING _____	C 08/18/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 000	INITIAL COMMENTS Facility Reported Incident of 8/4/2020/IL125667: F600 J & F689 J Complaint 2016342/IL125679: F600 J & F689 J A Partial Extended Survey was conducted.	F 000		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. 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. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to prevent resident to resident abuse, this failure led to the strangulation and subsequent death of R1 by R2. This applies to 1 of 6 residents (R1) reviewed for abuse in the sample of 6. This failure resulted in an immediate jeopardy. The immediate jeopardy began on 7/21/2020 when facility staff first became aware that R1 began complaining about his roommate. The	F 600	F600 S/S=J Corrective actions which will be accomplished for those residents found to have been affected by the deficient practice. 1. On 8.7.2020 The facility completed an entire house audit to ensure that there are	8/21/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 08/27/2020

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F 600	Continued From page 1 immediate jeopardy was identified on 8/5/2020. V1 (Administrator) was informed of the Immediate Jeopardy on 8/13/2020. The surveyor confirmed by observation, interview and record review that the immediate jeopardy was removed on 8/14/2020 but noncompliance remains at a Level Two because additional time is needed to evaluate the implementation and effectiveness of the in-service training. The findings include: R1's Face Sheet showed an original admission date of 6/30/2020 with diagnoses to include: Type II diabetes, Schizoaffective Disorder, and Major Depressive Disorder. R2's Face Sheet showed an original admission date of 6/17/2020 with diagnoses to include: Schizoaffective disorder, Bipolar, Anxiety, and psychosis not due to a substance or known physical condition. The facility's Amended Incident Report from the event on 8/4/2020 at 11:31 PM showed, there was a physical altercation between R1 and R2; R2 "grabbed (R1) around the neck. At some point, (R1) passed out. (R2) then came to the nurse's station to report the incident. (R1) remains in the neuro intensive care unit at (a local hospital). The Police Report dated 8/5/2020 showed an interview between police and R2. The report showed R2 and R1 had argued for the last week regarding R1 breaking the toilet and R1 breaking the window that morning. The report continued, R1 approached R2 and "he (R2) said he does not like when people larger than him get close to him	F 600	no concerns with existing room-mates. 2. 8.13.2020 The facility completed a second house audit to ensure that there are no concerns with existing room-mates. 3. R1 &R2 no longer reside in the facility \ How the facility will identify other residents having the potential to be affected by the same deficient practice: • All residents have the potential to be affected What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: 1. Implement abuse policy regarding staff supervision and prevention of abuse a. Forest City staff is educated on the abuse policy regarding staff supervision and prevention of abuse. i. Education completed 8.14.2020 ii. QAPI Audits initiated 8.14.2020 2. Develop/implement policy and procedures regarding early recognition of resident behaviors as possible precipitating events for resident to resident abuse a. Forest City educates facility staff on crises intervention/Behavior intervention techniques on hire, annually and as needed. i. Education completed 8.14.2020 ii. QAPI Audits initiated 8.14.2020 3. Staff training regarding identification of escalating resident behaviors and	

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F 600	Continued From page 2 because he was raped in the past." The report showed R1 punched R2 and R2 put him in a "headlock until (R1) he became unconscious." On 8/11/2020 at 10:30 AM, V22 R1's Attending Physician stated, there has been little change in R1's condition and "there is little hope for any neurological recovery...There is no etiology (cause) to explain his condition other than the strangulation. The CT was negative for fractures or subluxation. (dislocation)" On 8/12/2020 at 3:50 PM V26 Social Worker at local hospital stated R1 had passed away the afternoon of 8/12/2020. R1's Incident Note from 8/5/2020 at 1:25 AM showed, "At approximately (11:25 PM), client's roommate [R2] said to staff, 'I think I killed my roommate.' Staff rushed to client's room and observed him unresponsive lying face down on the bedroom floor. The 1st bed (roommate's) was pushed diagonally toward the 2nd bed (client's). A code blue and 911 was called. CPR was initiated ... " On 8/5/2020 at 3:07 PM, V11 Licensed Practical Nurse stated, R2 approached the second-floor nursing station at approximately 11:30 PM on 8/4/2020. V11 stated, "...(R2) goes by the phone and asks to use the phone and I told him it's kind of late thinking he wanted to call his Mom." V11 said, as R2 was walking away he said, "You need to call 911...my roommate jumped on me and punched me in the nose, and I think I killed my roommate." V11 stated, she ran to R1/R2's room and found R1 lying face down, unresponsive, pulseless, and not breathing.	F 600	reporting to administration. a. Forest City educates facility staff on crises intervention/behavior intervention techniques on hire, annually and as needed. i. Education completed 8.14.2020 ii. QAPI Audits initiated 8.14.2020 4. QAPI audits are being completed to properly implement increased supervision with incompatible roommates and identify a resident with a history of violence towards roommates initiated 8.14.2020 Quality Assurance Plans to monitor facility performance to make that the corrections are achieved and are permanent: • Results of the audits conducted, as stated above, by the DON or designee will be analyzed with the Quality Analysis Performance Improvement Committee for a period of no less than 4 months. • This POC is overseen and monitored by the quality and performance improvement committee, including the Administrator and medical director. Dates when corrective action will be completed: 8/21/2020	

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On 8/7/2020 at 10:30 AM, V7 R1 and R2's Emergency Room physician on 8/5/2020 said, "(R2) admitted to doing the choking but he didn't know how long he choked him for. (R2) said, he punched me so I choked him." V7 stated "...Strangulation could have caused the condition he came in with if it was long enough." V7 said, "He (R2) said they were fighting over the light in the room, one wanted it on and the other wanted it off. (R2) got up to turn it off and the other guy (R1) got up and punched him and that's when (R2) choked him."

On 8/5/2020 at 1:53 PM, R1 and R2's room had a broken window and the wall adjacent to the window had an approximate inch hole. On 8/5/2020 at 1:55 PM, V24 Housekeeping stated the broken window was a new issue and had occurred the night before.

On 8/7/2020 at 8:56 AM, R1 was observed in the Neuro Intensive Care Unit (ICU) at a local area hospital where he was on a ventilator. R1 had bruising to his bilateral knuckles and two quarter sized scabs to his left knee. V21 R1's ICU nurse suctioned R1's throat and no gag reflex was seen. V21 attempted painful stimuli and there was no response. On 8/7/2020 at 9:05 AM, V21 stated R1's sedative had been turned off for approximately 30 minutes and R1 was "not gagging" despite having a breathing tube in place.

R2's "Notice of Room Transfer" showed R2 was moved in with R1 on 7/16/2020.

On 8/6/2020 at 12:35 PM, V5 Social Services stated she was called to see R1 and R2 regarding an incident on 7/21/2020. V5 said, "When I walked in, (R2) was telling me that (R1)

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F 600	Continued From page 4	F 600		

said he smelled. So, (R2) asked about deodorant. I said, 'Do you want a room move?' He (R2) said if there was room he would like to move rooms; but I told him at that time we don't have a room available but when one comes available we will move him. He (R2) said he would like to move in the future when available...It's not like there wasn't room for him to move, but I didn't feel like it was necessary at the time. I did communicate that with (V4 SS Director) ..."

On 8/7/2020 at 12:19 PM, V20 R2's Legal Guardian stated, "(R2) told me, and (V4 SS Director) knows this, that he didn't really like his roommate. (R2) said (R1) talks about me under his breath and I told him he has to get along. I told him (V4) and I had a conversation; that (R2) had requested another roommate. She called me about it and I never heard any more about it... I felt like that she was going to move him to another room, but she was trying to find him a match." V20 said, "His (R2) impulse control is bad."

The facility's Abuse Prevention Program Facility Policy and Procedure reviewed on 1/4/2019 showed "Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm...Willful as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm."

The Immediate Jeopardy that began on 7/21/2020 was removed on 8/14/2020 when the facility took the following actions to remove the

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F 600	Continued From page 5 immediacy. 1. On 8/4/2020 the police were called at 11:30 PM. R2 was 1:1 supervision by staff until the police arrived and took over. 2. On 8/14/2020 the facility educated staff on prevention of resident to resident abuse. 3. On 8/14/2020 the facility educated staff on early recognition of escalating behaviors. 4. On 8/14/2020 the facility educated staff on crisis prevention. 5. On 8/14/2020 the facility completed a facility wide audit of roommate compatibility and developed policies for a 72-hour follow-up when roommates are changed. 9. On 8/14/2020 the facility audited its residents to determine appropriate level of supervision per the CHAR report. Based on the audit, residents were assigned to the appropriate group therapy. This audit has been added to the facility's QAPI to ensure residents are receiving appropriate therapy. 10. On 8/14/2020 the facility implemented a policy for weekly rounding on Moderate Risk residents to specifically ensure roommate compatibility. 11. On 8/14/2020 staff were educated to report any resident to resident conflict to the administrator, educated to separate the residents, educated to stay with the residents for safety, and educated to contact psych social. 12. On 8/14/2020 the facility trained staff on both verbal and non-verbal signs of increasing aggression and how to react to those signs.	F 600		

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F 600	Continued From page 6	F 600		

Based on observation, interview, and record review the facility failed to prevent resident to resident abuse, this failure led to the strangulation and subsequent death of R1 by R2. This applies to 1 of 6 residents (R1) reviewed for abuse in the sample of 6.

This failure resulted in an immediate jeopardy.

The immediate jeopardy began on 7/21/2020 when facility staff first became aware that R1 began complaining about his roommate. The immediate jeopardy was identified on 8/5/2020. V1 (Administrator) was informed of the Immediate Jeopardy on 8/13/2020. The surveyor confirmed by observation, interview and record review that the immediate jeopardy was removed on 8/14/2020 but noncompliance remains at a Level Two because additional time is needed to evaluate the implementation and effectiveness of the in-service training.

The findings include:

R1's Face Sheet showed an original admission date of 6/30/2020 with diagnoses to include: Type II diabetes, Schizoaffective Disorder, and Major Depressive Disorder.

R2's Face Sheet showed an original admission date of 6/17/2020 with diagnoses to include: Schizoaffective disorder, Bipolar, Anxiety, and psychosis not due to a substance or known physical condition.

The facility's Amended Incident Report from the event on 8/4/2020 at 11:31 PM showed, there was a physical altercation between R1 and R2;

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R2 "grabbed (R1) around the neck. At some point, (R1) passed out. (R2) then came to the nurse's station to report the incident. (R1) remains in the neuro intensive care unit at (a local hospital).

The Police Report dated 8/5/2020 showed an interview between police and R2. The report showed R2 and R1 had argued for the last week regarding R1 breaking the toilet and R1 breaking the window that morning. The report continued, R1 approached R2 and "he (R2) said he does not like when people larger than him get close to him because he was raped in the past." The report showed R1 punched R2 and R2 put him in a "headlock until (R1) he became unconscious."

On 8/11/2020 at 10:30 AM, V22 R1's Attending Physician stated, there has been little change in R1's condition and "there is little hope for any neurological recovery...There is no etiology (cause) to explain his condition other than the strangulation. The CT was negative for fractures or subluxation. (dislocation)"

On 8/12/2020 at 3:50 PM V26 Social Worker at local hospital stated R1 had passed away the afternoon of 8/12/2020.

R1's Incident Note from 8/5/2020 at 1:25 AM showed, "At approximately (11:25 PM), client's roommate [R2] said to staff, 'I think I killed my roommate.' Staff rushed to client's room and observed him unresponsive laying face down on the bedroom floor. The 1st bed (roommate's) was pushed diagonally toward the 2nd bed (client's). A code blue and 911 was called. CPR was initiated ... "

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F 600	Continued From page 8	F 600		

On 8/5/2020 at 3:07 PM, V11 Licensed Practical Nurse stated, R2 approached the second floor nursing station at approximately 11:30 PM on 8/4/2020. V11 stated, "...(R2) goes by the phone and asks to use the phone and I told him it's kind of late thinking he wanted to call his Mom." V11 said, as R2 was walking away he said, "You need to call 911...my roommate jumped on me and punched me in the nose and I think I killed my roommate." V11 stated, she ran to R1/R2's room and found R1 lying face down, unresponsive, pulseless, and not breathing.

On 8/7/2020 at 10:30 AM, V7 R1 and R2's Emergency Room physician on 8/5/2020 said, "(R2) admitted to doing the choking but he didn't know how long he choked him for. (R2) said, he punched me so I choked him." V7 stated "...Strangulation could have caused the condition he came in with if it was long enough." V7 said, "He (R2) said they were fighting over the light in the room, one wanted it on and the other wanted it off. (R2) got up to turn it off and the other guy (R1) got up and punched him and that's when (R2) choked him."

On 8/5/2020 at 1:53 PM, R1 and R2's room had a broken window and the wall adjacent to the window had an approximate inch hole. On 8/5/2020 at 1:55 PM, V24 Housekeeping stated the broken window was a new issue and had occurred the night before.

On 8/7/2020 at 8:56 AM, R1 was observed in the Neuro Intensive Care Unit (ICU) at a local area hospital where he was on a ventilator. R1 had bruising to his bilateral knuckles and two quarter sized scabs to his left knee. V21 R1's ICU nurse suctioned R1's throat and no gag reflex was

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F 600	Continued From page 9	F 600		

seen. V21 attempted painful stimuli and there was no response. On 8/7/2020 at 9:05 AM, V21 stated R1's sedative had been turned off for approximately 30 minutes and R1 was "not gagging" despite having a breathing tube in place.

R2's "Notice of Room Transfer" showed R2 was moved in with R1 on 7/16/2020.

On 8/6/2020 at 12:35 PM, V5 Social Services stated she was called to see R1 and R2 regarding an incident on 7/21/2020. V5 said, "When I walked in, (R2) was telling me that (R1) said he smelled. So, (R2) asked about deodorant. I said 'Do you want a room move?' He (R2) said if there was room he would like to move rooms; but I told him at that time we don't have a room available but when one comes available we will move him. He (R2) said he would like to move in the future when available...It's not like there wasn't room for him to move, but I didn't feel like it was necessary at the time. I did communicate that with (V4 SS Director)..."

On 8/7/2020 at 12:19 PM, V20 R2's Legal Guardian stated, "(R2) told me, and (V4 SS Director) knows this, that he didn't really like his roommate. (R2) said (R1) talks about me under his breath and I told him he has to get along. I told him (V4) and I had a conversation; that (R2) had requested another roommate. She called me about it and I never heard any more about it... I felt like that she was going to move him to another room but she was trying to find him a match." V20 said, "His (R2) impulse control is bad."

The facility's Abuse Prevention Program Facility Policy and Procedure reviewed on 1/4/2019

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showed "Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm...Willful as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm."

The Immediate Jeopardy that began on 7/21/2020 was removed on 8/14/2020 when the facility took the following actions to remove the immediacy.

1. On 8/4/2020 the police were called at 11:30 PM. R2 was 1:1 supervision by staff until the police arrived and took over.
2. On 8/14/2020 the facility educated staff on prevention of resident to resident abuse.
3. On 8/14/2020 the facility educated staff on early recognition of escalating behaviors.
4. On 8/14/2020 the facility educated staff on crisis prevention.
5. On 8/14/2020 the facility completed a facility wide audit of roommate compatibility and developed policies for a 72 hour follow-up when roommates are changed.
9. On 8/14/2020 the facility audited its residents to determine appropriate level of supervision per the CHAR report. Based on the audit, residents were assigned to the appropriate group therapy. This audit has been added to the facility's QAPI to ensure residents are receiving appropriate therapy.
10. On 8/14/2020 the facility implemented a policy for weekly rounding on Moderate Risk residents to specifically ensure roommate compatibility.
11. On 8/14/2020 staff were eductated to report

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F 600	Continued From page 11 any resident to resident conflict to the administrator, educated to seperate the residents, eductated to stay with the residents for safety, and educated to contact psych social. 12. On 8/14/2020 the facility trained staff on both verbal and non-verbal signs of increasing aggression and how to react to those signs.	F 600		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure the safety of one resident (R1) by not separating two incompatible roommates; the facility failed to properly implement increased supervision for a resident (R2); and the facility failed to identify a resident with a history of violence towards roommates. These failures resulted in a physical altercation between R1 and R2 and the subsequent strangulation and death of R1. This applies to 2 of 6 residents (R1, R2) reviewed for safety/supervision in the sample 6. This failure resulted in an immediate jeopardy. The immediate jeopardy began on 7/21/2020 when facility staff first became aware that R1 began complaining about his roommate. The immediate jeopardy was identified on 8/5/2020.	F 689	F689 S/S=J Corrective actions which will be accomplished for those residents found to have been affected by the deficient practice. 1. On 8.7.2020 The facility completed an entire house audit to ensure that there are no concerns with existing room-mates. 2. 8.13.2020 The facility completed a second house audit to ensure that there are no concerns with existing room-mates. 3. R1 & R2 no longer reside at the	8/21/20

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F 689	Continued From page 12 V1 (Administrator) was informed of the Immediate Jeopardy on 8/13/2020. The surveyor confirmed by observation, and record review that the immediate jeopardy was removed on 8/14/2020 but noncompliance remains at a Level Two because additional time is needed to evaluate the implementation and effectiveness of the in-service training. The findings include: R1's Face Sheet showed an original admission date of 6/30/2020 with diagnoses to include: Type II diabetes, Schizoaffective Disorder, and Major Depressive Disorder. R2's Face Sheet showed an original admission date of 6/17/2020 with diagnoses to include: Schizoaffective disorder, Bipolar, Anxiety, and psychosis not due to a substance or known physical condition. The Police Report dated 8/5/2020 showed an interview between police and R2. The report showed R2 and R1 had argued for the last week regarding R1 breaking the toilet and R1 breaking the window that morning. The report continued, R1 approached R2 and "he (R2) said he does not like when people larger than him get close to him because he was raped in the past." The report showed R1 punched R2 and R2 put him in a "headlock until he became unconscious." The facility's Amended Incident Report from the event on 8/4/2020 at 11:31 PM showed, there was a physical altercation between R1 and R2; R2 "grabbed (R1) around the neck. At some point, (R1) passed out. (R2) then came to the nurse's station to report the incident. (R1)	F 689	facility How the facility will identify other residents having the potential to be affected by the same deficient practice: • All residents have the potential to be affected What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur 1. System to determine if roommates are compatible and revisit as conflicts and behaviors arise. a. Interdisciplinary (IDT) reviews roommate selection on admission and room-changes. Social Service Case managers follow up for 72 hours post room move/new admission for roommate compatibility and weekly. Residents are encouraged to seek staff assistance when there is room-mate conflict. Staff is educated to intervene immediately when conflict with room mates arise and report the event to management. i. Audit initiated 8.14.2020 1. Audit: IDT review for room-mate selection on admission and room changes, 72 follow up to show that Social Services is following up on roommate compatibility on admission and weekly. Residents are encouraged to see out staff assistance with roommate conflict. ii. IDT and including Social Service education completed 8.14.2020 2. System to determine level of	

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F 689	Continued From page 13 remains in the neuro intensive care unit at (a local hospital). On 8/11/2020 at 10:30 AM, V22 R1's Attending Physician stated, there has been little change in R1's condition and "there is little hope for any neurological recovery. He has no real neurological activity...There is no etiology (cause) to explain his condition other than the strangulation. The CT was negative for fractures or subluxation. (dislocation)" On 8/12/2020 at 3:50 PM, V26 Social Worker at local hospital stated R1 had passed away this afternoon. On 8/5/2020 at 1:53 PM, R1 and R2's room had a broken window and the wall adjacent to the window had an approximate inch hole. On 8/5/2020 at 1:55 PM, V24 Housekeeping stated the broken window was a new issue and had occurred the night before. On 8/7/2020 at 8:56 AM, R1 was observed in the Neuro Intensive Care Unit (ICU) at a local area hospital where he was on a ventilator. R1 had bruising to his bilateral knuckles and two quarter sized scabs to his left knee. V21 R1's ICU nurse suctioned R1's throat and no gag reflex was seen. V21 attempted painful stimulus and there was no response. On 8/7/2020 at 9:05 AM, V21 stated his sedative had been turned off for approximately 30 minutes and R1 was "not gagging" despite having a breathing tube in place. R1's Incident Note from 8/5/2020 at 1:25 AM showed, "At approximately (11:25 PM), client's roommate [R2] said to staff, 'I think I killed my roommate.' Staff rushed to client's room and	F 689	supervision for the moderate risk offender per the CHAR report. a. A Social Service Case manager is assigned to the moderate risk offenders i. Baseline audit completed 8.14.2020 by Social Services to identify the offender level of residents (low, moderate and high-according to the State Police) ii. On-going QAPI audit initiated 8.14.2020 to ensure that residents have been identified at low, moderate or high risk. b. Resident is assigned to a group that is relevant to identified offenders that are moderate and high risk. i. Baseline audit completed 8.14.2020 to ensure that moderate and high-risk offenders are assigned to a group that is relevant to the identified risk level. ii. Groups are determined with IDT, resident and POA involvement to ensure the group is appropriate for the risk level. iii. Groups include: 1. Criminal history: Resident is evaluated for group programming which includes, but not limited to: a. New Beginnings i. Mental Illness and criminal behavior ii. Responsibility for behavior iii. Offense Cycle iv. Triggers to reoffend v. Cognitive distortions vi. Substance abuse and crime vii. Victimless crime viii. Finance and crime ix. Error common in criminal thinking x. Conflict resolution b. Anger Management i. What makes me angry	

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F 689	Continued From page 14	F 689		

observed him unresponsive lying face down on the bedroom floor. The 1st bed (roommate's) was pushed diagonally toward the 2nd bed (client's). A code blue and 911 was called. CPR was initiated ... "

On 8/5/2020 at 3:07 PM, V11 Licensed Practical Nurse stated, R2 approached the second floor nursing station at approximately 11:30 PM on 8/4/2020. V11 stated, "...(R2) goes by the phone and asks to use the phone and I told him it's kind of late thinking he wanted to call his Mom." V11 said, as R2 was walking away he said, "You need to call 911...my roommate jumped on me and punched me in the nose and I think I killed my roommate." V11 stated, she ran to R1/R2's room and found R1 lying face down, unresponsive, pulseless, and not breathing.

On 8/7/2020 at 10:30 AM, V7 R1 and R2's Emergency Room physician on 8/5/2020 said, "(R2) admitted to doing the choking but he didn't know how long he choked him for. (R2) said, he punched me, so I choked him." V7 stated "...Strangulation could have caused the condition he came in with if it was long enough." V7 said, "He (R2) said they were fighting over the light in the room, one wanted it on and the other wanted it off. (R2) got up to turn it off and the other guy (R1) got up and punched him and that's when (R2) choked him."

R2's "Notice of Room Transfer" showed R2 was moved in with R1 on 7/16/2020.

R1's Social Service note from 7/21/2020 at 10:21 AM showed, "SS (Social Services) approached resident in his room following a report that resident was not getting along with roommate.

ii. Recognize your anger
iii. Relaxation techniques
iv. Express anger constructively
v. Anger warning signs
vi. Negative results of anger
c. Symptom Education
i. What is mental illness
ii. Diagnosis
iii. Symptoms
iv. Coping
v. Controlling hallucinations
d. Human Sexuality
i. Safe sex
ii. Healthy relationships
iii. Building trust
iv. Romantic partners
v. Self Esteem
vi. Self Respect
vii. Violence
e. Social Skills and Communication
i. Appropriate behavior
ii. Accept social norms
iii. Dealing with people
iv. Resolving conflict-roommates -notifying staff
v. Learning how to start a conversation
vi. Learning nonverbal cues
vii. Talking on the telephone
viii. Making eye contact
ix. Shopping
x. Public transportation
xi. Manners
xii. Getting along with others
f. Substance Abuse
i. What is a narcotic
ii. Different types of drugs
iii. Alcohol effects on the brain
iv. Dependency and addiction
v. 10 things to do instead of drugs

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F 689	Continued From page 15 Staff inquired what the issue was, and (R1) replied, He smells, take your mask off and you can smell him. The CNA responded that resident's roommate had just showered but resident continued to state that the roommate had body odor. Staff suggested a room move but resident denied and continued to ignore..."(Incident occurred within 5 days or residents becoming roommates.) R2's Social Service Note from 7/21/2020 at 11:03 AM showed, "SS (Social Services) met with (R2) regarding an issue with roommate. It was reported that resident and roommate were not getting along...reminded him that if he still wants to transfer rooms, staff will assist him to move once a room became available..." Note signed by V5 Social Services (SS). On 8/6/2020 at 12:35 PM, V5 Social Services stated, in regard to the 7/21/202 SS note, "When I walked in, (R2) was telling me that (R1) said he smelled. So, (R2) asked about deodorant. I said Do you want a room move? He (R2) said if there was room he would like to move rooms; but I told him at that time we don't have a room available but when one comes available we will move him. He (R2) said he would like to move in the future when available...It's not like there wasn't room for him to move, but I didn't feel like it was necessary at the time. I did communicate that with (V4 SS Director) ..." On 8/7/2020 at 12:19 PM, V20 R2's Legal Guardian stated, "(R2) told me, and (V4 SS Director) knows this, that he didn't really like his roommate. (R2) said (R1) talks about me under his breath and I told him he has to get along. I told him (V4) and I had a conversation; that (R2)	F 689	iv. On-going QAPI audit is initiated 8.14.2020 1. Audit covers moderate and high-risk offenders are assigned to a group that is relevant to the identified risk level with collaboration of the resident, IDT, POA (if applicable) c. Social Services Case managers will meet with moderate risk residents weekly to review room-mate compatibility and follow up on other potential issues. The assigned case manager will document the weekly review to identify and roommate concerns i. Social Services Case manager education is complete 8.14.2020 Social Services Case managers will meet with moderate risk residents weekly to review room-mate compatibility and follow up on other potential issues. The assigned case manager will document the weekly review to identify roommate concerns ii. On-going QAPI audit initiated 8.14.2020 1. To ensure social services case managers have met with moderate risk residents weekly to address room mate concerns d. Front line staff is educated on identifying environmental concerns, physical and mental changes regarding possible aggression or a concern. Example include, but not limited to: Environment: broken window-what happened? Room is in a disarray more than usual -what happened? Broken equipment, holes in walls; what	

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F 689	Continued From page 16	F 689		

had requested another roommate. She called me about it and I never heard any more about it... I felt like that she was going to move him to another room, but she was trying to find him a match." V20 said, "His (R2) impulse control is bad."

On 6/29/2020 at 3:08 PM, the facility received medical records from R1's previous Long-Term Care facility. The following documents were contained in that packet. R1's Nurse Practitioner note from 4/1/2020 showed, "...He had gotten angry at his roommate and they got into an altercation. He states that this was a long time coming and they have had issues..." R1's physician note from 4/8/2020 showed, "...His behaviors have been a bit off lately. He had an argument with a roommate and has since had to change rooms..." R1's physician note from 5/7/2020 showed, "...His behaviors continue to be a bit of a problem. Recently he had some issues with roommates as well..."

On 8/7/2020 at 1:30 PM, V9 Director of Nursing at R1's previous long-term care facility, was contacted in regard to these roommate issues and R1's behavior. V9 stated, R1 was in a physical altercation with his roommate. V9 said, "After the roommate incident, we changed roommates and put him on 15-minute checks and we also did some anger management therapy with the two of them. (R1) was the instigator in that incident with the roommate. He (R1) was complaining that his roommate smelled, and he didn't want to live with him anymore; he was picking a fight."

On 8/7/2020 at 2:47 PM, V4 SS Director stated, she was not aware of the roommate issues

happened? Alert supervisor
Physical: change in appearance, blood on person-why? Alert supervisor. Mental changes: escalating behavior, behavior out of the ordinary, aggression-alert supervisor.
3. Staff is educated on identifying escalating behaviors and reporting to facility administration.
a. Staff is educated on hire, annually and as needed
i. All staff is educated on identifying escalating behaviors and reporting resident concerns to facility administration.
1. Education includes how to identify escalating behaviors and reporting resident concerns to facility administration after hours when managers are not present in the facility. A manager on duty is assigned during the week from 7A to 7PM. Social Services is in the facility until 9PM. The abuse coordinator (Administrator) is contacted after hours for behaviors that cannot be managed. The police, physician and family is notified, if applicable. The clinical department has a on-call staff member available 24/7. Department head numbers are posted at the nurse's station.
ii. Baseline audit completed 8.14.2020 to ensure staff education has been completed on escalating behaviors and reporting to facility administration.
iii. On-going QAPI audit and education regarding staff identifying resident escalating behaviors and reporting concerns to facility administration. The audit also covers that front-line staff know

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F 689	Continued From page 17 described in the medical records from R1's previous long-term care facility. V4 stated, "If I had known about the incident at (R1's previous long-term care facility) I would have looked at putting him (R1) in a single room by himself." R1's Care Plan showed, "Pt (patient) exhibits behaviors that include but are not limited to verbal and physical aggression towards other. On 7/8/2020 Pt displayed verbal aggression towards staff." R2's 6/15/2020 Background Check showed "Multiple Hits" regarding criminal past. R2's 6/17/2020 Discharge Order and Transition Record from a local Behavioral Hospital showed, "Reason for Admission: Danger to self with psychosis, Lack of impulse control, Danger to others with psychosis" The record continued, "Triggers and Stressors (Behaviors, situations and circumstances that put at emotional risk) are: Certain environments, People touching your stuff, and Like things to be a certain way." R2's Nursing Facility Placement Assessment Summary Information dated 6/17/2020 showed, "6-7 prior arrests (dates unknown) According to hospital staff, the patient has been arrested three times for stealing cars...and a few times for purchasing guns. In May 2020 he stole his grandfather's car. He was driving to Indiana and was stopped because he was driving on the wrong side of the road. It is unclear, but the patient may have a restraining order against him from his family...The patient has a tendency to start fires at his home or in hotels...He continues to exhibit poor reality contact with no insight or judgment to the severity of his MI (Mental	F 689	how to contact facility administration. 4. System to identify escalating behaviors and implement/develop policy and procedures to manage behaviors to protect resident's safety. a. Forest City educates facility staff on crises intervention/Behavior intervention techniques on hire, annually and as needed. i. Re-Education initiated 8.12.2020 on identifying escalating behaviors and managing behaviors to protect resident safety. ii. On-going QAPI Audits initiated 8.14.2020 to identify escalating behaviors and manage resident behaviors to protect resident safety b. Facility staff is educated on Abuse and Resident Rights upon hire, annually and as needed. i. Education audit on abuse training and resident rights On-going completed 8.14.2020 ii. QAPI Audits initiated 8.14.2020 to ensure if aware of the abuse reporting requirements and resident rights. 5. QAPI audits to prevent resident to resident abuse initiated 8.14.2020 Quality Assurance Plans to monitor facility performance to make that the corrections are achieved and are permanent: • Results of the audits conducted, as stated above, by the DON or designee will be analyzed with the Quality Analysis	

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F 689	Continued From page 18 Illness)...The patient was hospitalized on 5/16/20 (for) worsening psychosis, inability to care for self, being kicked out of family homes and hotels for destructive behaviors, and paranoia with no regard to his own well-being. His mother has legal guardianship of the patient due to his inability to care for himself. He is rather impulsive with no regard for himself or others (i.e. his paranoia was so intense he tried to jump out of a moving car with his mother driving just before being hospitalized)...He has gone to Indiana on several occasions to purchase firearms because he does not need a FOID (Firearms Owner Identification) card. He has been court ordered to treatment multiple times..." R2's Identified Offenders Program (commonly referred to as CHAR report) shows him to be a "Moderate Risk-This resident requires closer supervision and more frequent observation than standard or routine for most resident in an open facility..." R1 and R2's room was the second to last room (end) of their hallway. On 8/7/2020 at 11:34 AM, V19 Certified Nursing Assistant stated, "I was not aware of their (R1, R2) backgrounds or histories. We were not doing any special supervision for them (R1, R2). We are supposed to do rounds on everyone, every 2 hours. We only do 15-minute checks when warranted; (R1 or R2) were not on 15 minute checks whenever I worked with them." On 8/14/2020 at 8:45 AM, V15 Licensed Practical Nurse stated, there are some residents that are monitored more frequently; however, "(R1) and (R2) were not on any increased monitoring."	F 689	Performance Improvement Committee for a period of no less than 4 months. • This POC is overseen and monitored by the quality and performance improvement committee, including the Administrator and medical director. Dates when corrective action will be completed: 8/21/2020	

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F 689	Continued From page 19 On 8/13/2020 at 11:50 AM, V4 Social Service Director stated the only increased supervision R2 received was 1 to 1 group therapy twice a week and "usually a daily visit" by social services. R2's 6/30/2020 Care Plan Conference Participation Log showed there was no staff, family, or guardian participation. On 8/7/2020 at 12:19 PM, V20 R2's Legal Guardian stated she was not contacted for a care plan meeting. V20 stated she had to contact the facility to set up the meeting and it was not done until a week before the incident. The Immediate Jeopardy that began on 7/21/2020 was removed on 8/14/2020 when the facility took the following actions to remove the immediacy. 1. On 8/4/2020 the police were called at 11:30 PM. R2 was 1:1 supervision by staff until the police arrived and took over. 2. On 8/14/2020 the facility educated staff on prevention of resident to resident abuse. 3. On 8/14/2020 the facility educated staff on early recognition of escalating behaviors. 4. On 8/14/2020 the facility educated staff on crisis prevention. 5. On 8/14/2020 the facility completed a facility wide audit of roommate compatibility and developed policies for a 72-hour follow-up when roommates are changed. 9. On 8/14/2020 the facility audited it residents to determine appropriate level of supervision per the CHAR report. Based on the, audit residents were assigned to the appropriate group therapy. This audit has been added to the facility's QAPI to	F 689		

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F 689	Continued From page 20 ensure residents are receiving appropriate therapy. 10. On 8/14/2020 the facility implemented a policy for weekly rounding on Moderate Risk residents to specifically ensure roommate compatibility. 11. On 8/14/2020 staff were educated to report any resident to resident conflict to the administrator, educated to separate the residents, educated to stay with the residents for safety, and educated to contact psych social. 12. On 8/14/2020 the facility trained staff on both verbal and non-verbal signs of increasing aggression and how to react to those signs	F 689		