STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146054	A. BUILDING _____ B. WING _____	07/29/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GALLATIN MANOR	900 WEST RACE STREET RIDGWAY, IL 62979

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0600 **Level of harm -** Actual harm **Residents Affected -** Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and observations the facility failed to prevent resident to resident abuse for 6 of 6 residents (R2, R7, R8, R9, R10 and R11) reviewed for abuse investigations in the sample of 11. This failure resulted in residents (R10) and (R11) falling, and as a result of the fall, R10 was hospitalized for [REDACTED]. Findings include: 1.) The facility's Risk Management form dated 6/13/20 documents under Statement; V11 (Licensed Practical Nurse) stated R10 came into the dining room and was messing with the chairs and R8 moved one of the chairs back. R10 got mad and was yelling at R8 and he repeatedly hit his walker against R8's chair. The facility's form titled, Report of Illinois Department of Public Health dated 6/13/20 documents under Summary: At 6:00 PM, R10 was being verbally and physically aggressive with R11 over some chairs in the dining room. (Referenced above) V20 (Housekeeper) yelled at V11 that R10 and R11 were fighting. The report documents that when V11 got to the two residents, they were both punching each other in the face and R11 fell on top of R10. When both residents fell , R10 fell on his right side and was screaming, He broke my leg! R11 had his vital signs taken and was helped up to a chair and both residents were taken to a local hospital emergency room for further evaluation. R10s' electronic medical record, under Medical [DIAGNOSES REDACTED]. R10's Progress Notes dated 6/13/20 documents under Note Text: R10 was in the dining room punching another resident, R11, in the face when V20 called out to V11. During the altercation, while R10 and R11 were swinging at each other R11 fell on top of R10. R10 fell on to his right hip and he started screaming He broke my leg! R10 and R11 were evaluated by V11 and both residents were sent to the local hospital. R10's Progress Notes also document R10 was transferred and admitted to a hospital in a neighboring state for a [MEDICAL CONDITION] hip. R10's Minimum Data Set ((MDS) dated [DATE], Section E documents behavior of verbal symptoms occurs 1-3 days per week and under physical behavior directed toward others is marked behavior not exhibited. R10's MDS dated [DATE] documents verbal and physical behaviors not assessed. R10's Care Plan dated 4/23/20, documents under, Intervention; Intervene as necessary to protect R10's rights and safety of others. Approach/speak in a calm manner. Divert attention. Remove from situation and take to alternative location as needed. R10's Care Plan dated 1/30/20 documents under Focus; R10 currently has an alteration in his behavior status related to physically aggressive behavior and verbally aggressive behavior. R11's medical record under Medical [DIAGNOSES REDACTED]. R11's MDS dated [DATE], Section E, documents physical behavior directed toward others occurs 1-3 times per week and verbal behavioral symptoms directed toward others occurs 1-3 days per week. R11's Care Plan dated 6/4/20 documents under Focus; R11 has the potential to demonstrate episodes of agitation and has the potential to be physically aggressive. R11's Care Plan dated 3/5/19, documents under, Intervention; Intervene before agitation escalates; Guide away from source of distress to a quiet area; Engage calmly in conversation. There is no documentation in R10's or R11's medical record on any of the interventions being initiated, and there is no documentation on the effectiveness of any of the interventions in R10's or R11's medical record or in their Care Plans. There is no documentation that R10 or R11's behaviors were being tracked. On 7/29/20 at 6:00 PM via phone, V11 stated she had just got to work at 6:00 PM and was getting report from the day shift.V11 stated the residents had already had their evening meal and about 5 residents were in the dining room and staff were busy getting people ready for bed. V11 stated it's always busy at that time of the day and the C.N.A.'s were in and out of the dining room. V11 stated R10 was moving chairs and started knocking on R8's wheelchair with his walker and yelling at her and R8 asked him several times to stop. V11 stated R11 saw that R10 kept hitting R8's wheelchair and R11 asked R10 to stop, and when R10 wouldn't stop, R11 got up and went over to R10 and they started hitting each other in the face with their fists. V11 said, during the fist fight, they both lost their balance and R11 fell on top of R10, and when they hit the floor, R10 was screaming that his right leg hurt and that R11 broke his leg. V11 stated she called an ambulance for both residents and they were taken to the hospital and R10 ended up going to the hospital in Indiana for a fractured right hip and R11 came back to the facility after being checked out. On 7/28/20 at 8:30 AM, V2 (Interim Director of Nursing) stated she didn't see the incident/resident altercation between R10 and R11. V2 stated she was told that R10 and R11 were fighting over chairs, and they got into a fist fight that resulted in R10 falling to the floor and fracturing his right hip. V2 stated she isn't sure who hit who first. V2 also stated when R10 started moving the dining room chairs, R8 was also in the dining room and moved one of the chairs back and R10 got really upset and hit her chair with his walker and that's when R10 and R11 got into it. On 7/27/20 at 2:00 PM, V20 stated she was the only employee in the dining room and she saw R10 banging on R8's chair with his walker, then R10 and R11 got into it and started hitting each other in the face with their fists. V20 states she didn't know who hit who first, because she was getting the nurse to come to the dining room. V20 stated both residents were standing during the confrontation. 2.) The facility's form titled, Report to Illinois Department of Public Health dated 6/12/20 documents under, Summary: Resident to Resident altercation in their room. Male resident R10 had a broom handle and a pair of scissors and R10 attacked his roommate, R7 while in bed, hitting R7 in the head with the broom handle and scratching his chest with the scissors. Scratches were noted and EMS and local police were called. Resident (R10) was taken to the hospital and R7 was assessed by EMS. Neurological assessments being completed for the next 24 hours. No further distress is noted to R7. R7's Progress Notes dated 6/12/20 document, R7 came up to nurses station without any clothes on. V10 (Certified Nurses Aide) went to R7's room to get his clothes, and found R10 sitting on the edge of bed with what appeared to be a large knife and a broom stick. V10 came back up to nurses station to report to V11 (Licensed Practical Nurse) what she saw. V11 went down to resident room with V10 and looked into the opened door to find R10 sitting on edge of bed with broom stick and large scissors. V11 asked R10 if he was ok to which he replied that man attacked me. V11 pulled the door closed and went back to the nurses station to call V1 (Administrator) and 911. V11 asked R7 what happened and he said I got in a physical fight. He hit me first. He hit me with a broom in the head. I'm not hurt. R7 had a scrape across his abdomen but did not appear to be in distress. V10 put R7's clothes on and took him to the dining room to eat while the police investigated further. R7 was evaluated by the Emergency Medical Service staff. On 7/22/20 at 10:45 AM, V1 (Administrator) stated R7 and R10 were roommates and that R10 was prejudiced against black people. V1 stated on 6/12/20, R7 came to the Nurse's Station without any clothing and V10 (Certified Nurses Aide) walked to R7's room to get him clothes and when V10 opened the door, R10 was sitting on his bed holding a broom handle and what V10 thought was a knife. V1 stated that when asked by the staff if R10 was alright, R10 responded that R7 came into his room through the window. V1 stated when the staff asked R7 what happened, R7 told them that he got into a fight and R10 hit him on the head with a broom. V1 stated R10 had a pair of scissors and a broom handle that he got out of the adjoining room. V1 stated they called the police about the resident to resident altercation immediately and R10 was sent out to the hospital for evaluation. V1 also stated R7 was assessed by the emergency medical staff and they continued to monitor R7 for 24 hours and he was fine. V1 stated she notified the doctor, R7 and R10's families, they did an investigation and sent a report in to IDPH. V1 stated R7

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

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F 0600 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) was moved to another hall and the incident was added to R7's Care Plan. V1 also stated the room next door to R7 and R10 was unoccupied because V19 (Maintenance) was doing some construction on that room. V1 stated V19 (Maintenance) failed to lock the door that was next to R7 and R10's room. R10's Minimum Data Set ((MDS) dated [DATE], Section E documents behavior of verbal symptoms occurs 1-3 days per week and under physical behavior directed toward others is marked Behavior not exhibited. R10's MDS dated [DATE] documents verbal and physical behaviors not assessed. R10's Care Plan dated 4/23/20, documents under, Intervention; Intervene as necessary to protect R10's rights and safety of others. Approach/speak in a calm manner. Divert attention. Remove from situation and take to alternative location as needed. R10's Care Plan dated 1/30/20 documents under Focus; R10 currently has an alteration in his behavior status related to physically aggressive behavior and verbally aggressive behavior. R10's Progress Notes dated, 6/12/2020 at 2:50 pm; Transfer to Hospital Note Text: resident was transferred to (a local hospital) for psychiatric evaluation after incident with another resident (R7). There is no further documentation in R10's medical record/Care Plan to address his physical or verbal aggression regarding this incident or that R10 had prejudices against people of color. The facility has done no behavior tracking on R10. 3). a. A report titled 'Initial IDPH (Illinois Department of Public Health) Incident and/or Abuse Notification' dated 12/4/19 includes information regarding a resident to resident altercation between R2 and R8 and lists the incident as alleged physical abuse, no injury to R8, and police notified. The 'Final IDPH Incident and/or Abuse Notification' dated 12/4/19 documents the following: Another resident R8, was wheeling herself across the dining room. R2 got up from his wheelchair and struck R8 three times in the back and shoulder region. It was a witnessed incident by staff. Staff were unable to get between them to prevent the incident, R2 was unprovoked. R8 received a head to toe assessment, no injuries noted at this time. R2 was removed from the dining room and placed on 1 on 1 visual, R2 received a medication adjustment from the Behavioral Center. R2's EMR Progress Note, dated 12/4/19, documents the following: This nurse and CNA (V12) heard yelling in the dining room. Upon looking from nurses' station to dining room CNA (V12) saw R2 strike R8 three times in the back and shoulder as R8 was wheeling herself to the dining room table. The residents were immediately separated and R2 was put on one-on-one supervision and 15-minute checks. POA's (Power of Attorney), MDs (Physician), Ombudsman, Police, DON V13, and Administrator V1 notified. R8's EMR Progress Note, dated 12/4/19, documents the following: This nurse and CNA (V12) heard yelling in the dining room. Upon looking from nurses' station to dining room (V12) saw (R2) strike (R8) three times in the back and shoulder while R8 was wheeling herself to the dining room table. Residents were immediately separated and (R2) was placed on 15-minute checks with one-on-one supervision. (R8) was assessed head-to-toe with redness noted on her left rear shoulder and left front shoulder. DON, Admin, MDs, POAs, Ombudsman, and Police notified. R2's MDS (Minimum Data Set), dated 1/31/20, Section C (Cognition) BIMS (Brief Interview Mental Status) score is 6, indicating R2 is severely impaired. Section E200 (Behaviors) of the MDS indicates resident exhibits physical behavior symptoms directed toward others such as hitting, kicking, pushing, scratching, and grabbing. R2's Electronic Medical Record's (EMR) [DIAGNOSES REDACTED]. R2's Care Plan includes the following focus: R2 has impaired cognitive function/dementia or impaired thought processes relate to disease Process or other specific disorders of the brain, R2 is considered at risk for abuse/neglect due to poor insight/poor judgement and difficulty communication, R2 has potential to demonstrate physical behaviors. The Care Plan does not include interventions related to these areas of focus. R8's MDS, dated [DATE], Section C - BIMS is scored as a 6, indicating R8 is severely impaired. Section E (Behaviors) indicates No Behaviors. R8's EMR [DIAGNOSES REDACTED]. On 7/27/20 at 9:45AM, V1 (Administrator) stated regarding the 12/4/19 incident concerning R2 and R8, that medications were increased for R2, R2 was placed on 1 on 1 supervision and 15 minutes checks to keep all residents safe. V1 did not think that this was abuse because this was R2 and R8's first altercation. V1 stated R2's actions toward R8 was out of the blue and was not provoked by R8. On 7/22/20 and 7/27/20, R8 is noted sitting in a wheelchair and peddling with her feet. R8 is carrying 2 baby dolls and is peddling up and down the center hall, into her room, and into the dining room. R8 does not interact with staff or other residents. b. A report titled 'Incident Report Form- IDPH Notification, dated 12/27/19, includes information regarding a resident to resident altercation between R2 and R8, and lists the incident as resident to resident, reddened area, alleged physical abuse, non-fatal, Physician, Family, and Police notified. The 'Final IDPH and/or Abuse Notification' dated 12/27/19, documents the following: R8 was wheeling herself into dining room area. R2 stood up from his wheelchair and stumbled over to R8. R2 punched her in the chest without provocation. R2 was redirected to his room. R8 received head to toe assess. Reddened area found. R2 had med adjustment recently from prior incident. 15-minute checks were implemented. R2's EMR Progress Note, dated 12/27/19, documents the following: Resident (R2) was witnessed getting up out of w/c (wheelchair), walked over to (R8) and made contact to her chest with a closed fist. Residents were separated. (R2) was removed from area. Resident is currently in his room. 1 to 1 is initiated only when he comes out of his room. Will continue to monitor. R8's EMR Progress Note, dated 12/27/19 at 2:19 PM, documents the following: Resident (R8) was in w/c in dining room. Wandered close to (R2). He got up out of w/c and hit resident (R8) in the center of her chest with his fist closed. R8 was removed from area immediately. On my examination I noted a large red area in the center of R8's chest. No bruising noted. No other red areas noted. Will continue to observe. Doctor and Power of Attorney notified of incident. Will continue to monitor. On 7/27/20 at 9:55AM, V1 stated the following regarding R2 and R8's incident on 12/27/19: V1 thought R2 was doing better due to the recent medication adjustment on 12/4/19. V1 did not think it was abuse because it was a resident to resident altercation. V1 stated it was too random to be intentional. R2 was placed on 15-minute checks and one on one when out of his room. No behavior modifications were done due to R2's [MEDICAL CONDITION], no interventions were attempted at this time. Because of R2's [MEDICAL CONDITION] the staff was only able to do one on one supervision. V1 also stated that R2 was frequently combative with staff. c. A report titled 'Incident Report Form-IDPH Notification, dated 3/19/20, documents R2 smacked R8 in the back. They were separated with no injuries. R2 was placed on 15-minute checks. The 'Final IDPH and/or Abuse Notification' dated 3/19/20, documents the following: R2 was in the dining room with other assisted residents. R2 reached across the table and slapped R8. Staff immediately separated them. R8 received head to toe check. No injuries noted. R2 was placed on 15-minute checks. R2's medications were reviewed. R2's EMR Progress Note, dated 3/19/20, documents the following: Res (resident) was out in dining room this morning and it was reported by staff that he (R2) hit another resident (R8), separated residents, discussed with res about how it is not appropriate to hit others. R8's EMR Progress Note, dated 3/19/20, documents the following: Res was in dining room waiting for breakfast, it was reported to this staff that another res (R2) hit her, assessed her for injuries, no injuries noted, res denies c/o's, separated residents from each other, will mx (monitor). On 7/28/20 at 9:55AM, V21 (Registered Nurse) stated that R8 was very afraid of R2, as R2 targeted her. V21 stated she never knew why he was aggressive toward R8 and would hit her. The only interventions we put into place is the one on one supervision when he was in the dining room. R2 was very fast in his wheelchair and he could slip by the nurse's station and enter the dining room where R8 often stayed. V21 stated she was working the day of this altercation between R2 and R8 occurred. On 7/27/20 at 10:05AM, V1 stated that she did not think it was abuse as it was not witnessed. R2 and R8 were not at the same table. R2 went to R8's table and slapped her, this was not witnessed by staff. On 7/28/20 at 8:35AM, V1 stated the incident on 3/19/20 was witnessed by V24, (CNA) but she did not see what caused the incident. On 7/27/20, V14 (CNA/Certified Nurse Aide), V15 (Housekeeping/Laundry), V16 (CNA), V4 (Registered Nurse), and V17 (CNA) all stated R2 was frequently combative and often targeted R8 while in the dining room. V14 stated that R8 has dementia and cannot defend herself. V17 stated that R8 never provoked R2. 4). A report titled 'Incident Report Form-IDPH Notification', dated 4/19/20, documents the following: R2 was in the dining room. R9 was in the dining room. R9 started yelling that he had been hit by R2 on the right side of his head by R2's fist. Residents were separated and assessed for injuries. Residents were 1 on 1 with staff while dining. The Incident Report Form-IDPH Notification documents the incident as resident to resident, no apparent injury, and physical abuse. The final IDPH Incident and/or Abuse Notification, dated 4/19/20, documents the following: R2 was in the dining room. R9 was in the dining room. R9 began yelling that he had been hit by R2 on the right side of his face by R2's fist. They were immediately separated and assessed for injuries. No injuries noted. R2 was sent to a behavior center for medication adjustment. R9's EMR Progress Note, dated 4/19/20, documents the following: Was alerted to the dining room by staff after res (R9) was heard yelling that he had been hit by (R2), res (R9) states that res (R2) hit him with his fist on the right side of his head, right ear red, some bruising is starting to develop and right side of face is red, no swelling noted, res (R9) denies any other injures or complaints, no other injuries noted, Administrator notified, MD notified, (POA) notified, DON notified, will mx (Monitor). R9's Progress note dated 4/20/20 documents the following: Awakens easily to verbal stimuli. Denies any pain. Cont. with Bruising to right ear and right side of face. Will monitor further. R2's EMR Progress Note, dated 4/19/20, documents the following: Was alerted to the dining room by staff, res (R2) allegedly hit (R9) with fist in the head per (R9); for unknown reason. Staff responded to (R9) yelling, (R9) was noted to have redness to right ear and right side of face, no injuries noted to res

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F 0600 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 2) (R2) allegedly initiated incident, residents separated and staff 1:1 monitoring dining room, Administrator notified, POA notified, DON notified, MD notified, res assessed for injuries, no injuries noted, denies c/o's, res (R2) ate meal in dining room supervised then went to his room where he does not have a roommate, will mx. R9's EMR MDS, dated [DATE], Section C - BIMS is scored a 5, indicating severe cognitive impairment. Section E- Behavior is rejects care and wandering. R9's EMR [DIAGNOSES REDACTED]. On 7/27/20 at 10:00AM, V1 stated that there were no witnesses, with R9 stating R2 hit him. R2 was placed on one on one, abuse was not known due to the fact that R9 can provoke other residents. No interventions were put into place since R2 was going to a Behavioral Center for an inpatient stay in just a few days. R2 was admitted to the Behavior Center on 4/21/20. 5). The facility's Policy and Procedure on Resident to Resident Incidents dated November 5, 2015 documents under the heading, Purpose; To prevent repeated incidents and ensure appropriate reporting. The facility's Policy and Procedure on Abuse Prevention and Reporting, dated November 5, 2019 documents under, Policy Statement; Residents must not be subjected to abuse by anyone. In the second paragraph of this same policy, documents; The facility shall implement programs and interventions individualized to the resident.
F 0607 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Develop and implement policies and procedures to prevent abuse, neglect, and theft.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to implement their Abuse Prevention Policy and Procedure, thoroughly investigate and to prevent further abuse for 6 of 6 residents (R2, R7, R8, R9, R10 and R11) reviewed for abuse in the sample of 11. Findings include: 1. The facility's Policy and Procedure for Abuse Prevention and Report, revised 11/5/19, documents the following: Each resident has the right to be free from abuse, corporal punishment and involuntary seclusion. Residents must not be subjected to abuse by anyone, including, but not limited to facility staff, other residents, . or other individuals. In order to prevent occurrences of abuse, this facility will screen potential employees, train all staff, proactively attempt to prevent abuse, identify the potential for abuse, investigate any allegation of abuse, and report instances of abuse to DOH (Department of Health) as required. The facility will implement appropriate assessment and care planning tools to identify, correct, and intervene in situations in which abuse is likely to occur. 2.) The facility's Risk Management form dated 6/13/20 documents under Statement; V11 (License Practical Nurse) stated R10 came into the dining room and was messing with the chairs and R8 moved one of the chairs back. R10 got mad and yelled at R8 and he started hitting his walker against her chair. The facility's form titled, Report of Illinois Department of Public Health dated 6/13/20 documents under, Summary: At 6:00 PM, R10 was being verbally and physically aggressive with R11 over some chairs in the dining room. (Referenced above) V20 yelled for V11 to come and help because R10 and R11 were fighting. The report documents that when V11 got to the two residents, they were both punching each other in the face and R11 fell on top of R10. When both residents fell , R10 fell on his right side and was screaming, he broke my leg. R11 had his vital signs taken and was helped up to a chair and both residents were taken to a local hospital emergency room for further evaluation. R10's Progress Notes dated 6/13/20 documents under Note Text: R10 was in the dining room punching another resident, R11, in the face when V20 (Housekeeper) called out to V11. During the altercation, while R10 and R11 were swinging at each other R11 fell on top of R10. R10 fell on to his right hip and he started screaming He broke my leg! R10 and R11 were evaluated by V11 and both residents were sent to the local hospital. R10's Progress Notes also document R10 was transferred and admitted to a hospital in a neighboring state for a [MEDICAL CONDITION] hip. R10's Minimum Data Set ((MDS) dated [DATE], Section E documents behavior of verbal symptoms occurs 1-3 days per week and under physical behavior directed toward others is marked behavior not exhibited. R10's MDS dated [DATE] documents verbal and physical behaviors not assessed. R10's Care Plan dated 4/23/20, documents under, Intervention; Intervene as necessary to protect R10's rights and safety of others. Approach/speak in a calm manner. Divert attention. Remove from situation and take to alternative location as needed. R10's Care Plan dated 1/30/20 documents under Focus; R10 currently has an alteration in his behavior status related to physically aggressive behavior and verbally aggressive behavior. R11's MDS dated [DATE], Section E documents Physical behavior directed toward others occurs 1-3 times per week and Verbal behavioral symptoms directed toward others occurs 1-3 days per week. R11's Care Plan dated 6/4/20 documents under Focus; R11 has the potential to demonstrate episodes of agitation and has the potential to be physically agressive. R11's Care Plan dated 3/5/19, documents under, Intervention; Intervene before agitation escalates; Guide away from source of distress to a quiet area; Engage calmly in conversation. There is no documentation that the facility staff were supervising and intervening to prevent potential harm to R8 and eliminate harm to R10 and R11 per the facility policy. On 7/28/20 at 8:30 AM, V2 (Interim Director of Nursing) stated she didn't see the incident/resident altercation between R10 and R11. V2 stated she was told that R10 and R11 were fighting over chairs, and they got into a fist fight that resulted in R10 falling to the floor and fracturing his right hip. V2 stated she isn't sure who hit who first. V2 also stated when R10 started moving the dining room chairs, R8 was also in the dining room and moved one of the chairs back and R10 got really upset and hit her chair with his walker, and that's when R10 and R11 got into it. On 7/27/20 at 2:00 PM, V20 stated she was the only employee in the dining room and she saw R10 banging on R8's chair with his walker, then R10 and R11 got into it and started hitting each other in the face with their fists. V20 states she didn't know who hit who first, because she was getting the nurse to come to the dining room. V20 stated that both residents were standing during the fight. 3.) The facility's form titled, Report to Illinois Department of Public Health dated 6/12/20 documents under, Summary: Resident to Resident altercation in their room. Male resident R10 had a broom handle and a pair of scissors and R10 attacked his roommate, R7 while in bed, hitting R7 in the head with the broom handle and scratching his chest with the scissors. Scratches were noted and EMS and local police were called. Resident, R10 was taken to the hospital and R7 was assessed by EMS. Neurological assessments being completed for the next 24 hours. No further distress is noted to R7. R7's Progress Notes dated 6/12/20 document, R7 came up to nurses station without any clothes on. V10 (Certified Nurses Aide) went to R7's room to get his clothes, and found R10 sitting on the edge of bed with what appeared to be a large knife and a broom stick. V10 came back up to nurses station to report to V11 (Licensed Practical Nurse) what she saw. V11 went down to resident room with V10 and looked into the opened door to find R10 sitting on edge of bed with broom stick and large scissors. V11 asked R10 if he was ok to which he replied that man attacked me. V11 pulled the door closed and went back to the nurses station to call V1 (Administrator) and 911. V11 asked R7 what happened and he said I got in a physical fight. He hit me first. He hit me with a broom in the head. I'm not hurt. R7 had a scrape across his abdomen but did not appear to be in distress. V10 put R7's clothes on and took him to the dining room to eat while the police investigated further. R7 was evaluated by the Emergency Medical Service staff. On 7/22/20 at 10:45 AM, V1 (Administrator) stated R7 and R10 were roommates and states R10 had a prejudice against black people. V1 stated on 6/12/20, R7 came to the Nurse's Station without any clothing and V10 (Certified Nurses Aide) walked to R7's room to get him clothes and when V10 opened the door, R10 was sitting on his bed holding a broom handle and what V10 thought was a knife. V1 stated R10 told the staff that R7 came into his room through the window when he was asked by the staff if he was alright. V1 stated when the staff asked R7 what happened, R7 told them that he got into a fight and R10 hit him on the head with a broom. V1 stated R10 had a pair of scissors and a broom handle that he got out of the adjoining room. V1 stated they called the police about the resident to resident altercation immediately and R10 was sent out to the hospital for evaluation. V1 also stated R7 was assessed by the emergency medical staff and they continued to monitor R7 for 24 hours and he was fine. V1 stated she notified the doctor, R7 and R10's families, they did an investigation and sent a report in to IDPH. V1 stated R7 was moved to another hall and the incident was added to R7 and R10's Care Plans.V1 also stated the room next door to R7 and R10 was unoccupied because V19 (Maintenance) was doing some construction on that room. V1 stated V19 failed to lock the door that was next to R7 and R10's room. R10's Minimum Data Set ((MDS) dated [DATE], Section E documents behavior of verbal symptoms occurs 1-3 days per week and under physical behavior directed toward others is marked Behavior not exhibited. R10's MDS dated [DATE] documents verbal and physical behaviors not assessed. R10's Care Plan dated 4/23/20, documents under, Intervention; Intervene as necessary to protect R10's rights and safety of others. Approach/speak in a calm manner. Divert attention. Remove from situation and take to alternative location as needed. R10's Care Plan dated 1/30/20 documents under Focus; R10 currently has an alteration in his behavior status related to physically agressive behavior and verbally aggressive behavior. R10's Progress Notes dated 6/12/20 at 2:50; Transfer to Hospital Note Text: resident was transferred for psychiatric evaluation after incident with another resident. There is no further documentation in R10's medical record/Care Plan to address his physical or verbal aggression regarding this incident and no new interventions added. The facility has done no behavior tracking on R10 to monitor how many times abuse occurrences have happened, or what interventions worked for R10. 4). a. The 'Final IDPH Incident and/or Abuse Notification' dated 12/4/19 documents the following: Another resident R8, was wheeling herself across the dining room. R2 got up from his wheelchair and struck R8 three times in the back and shoulder region. It was a witnessed incident

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	146054	A. BUILDING _____ B. WING _____	07/29/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GALLATIN MANOR	900 WEST RACE STREET RIDGWAY, IL 62979

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0607 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 3) by staff. Staff were unable to get between them to prevent the incident, R2 was unprovoked. R8 received head to toe assessment, no injuries noted at this time. R2 was removed from the dining room and placed on 1 on 1 visual, R2 received a medication adjustment from the Behavioral Center. On 7/27/20 at 9:45 AM, V1 (Administrator) stated regarding the 12/4/19 incident concerning R2 and R8, that medications were increased for R2, R2 was placed on 1 on 1 supervision and 15 minutes checks to keep all residents safe. V1 did not think that this was abuse because this was R2 and R8's first altercation. V1 stated R2's actions toward R8 was out of the blue and was not provoked by R8. R8's Weekly Nurse Skin Review, dated 12/5/19 and 12/12/19, documents bruise to left upper arm. The Investigation Notes and Findings, dated 12/4/19, documents: Determination- Based on evidence from head to toe check, witness statement, and interviews, (R2) did hit (R8) while in the dining room. There was no factors or evidence that he was provoked in any way. b. The 'Final IDPH and/or Abuse Notification' dated 12/27/19, documents the following: R8 was wheeling herself into dining room area. R2 stood up from his wheelchair and stumbled over to R8. R2 punched her in the chest without provocation. R2 was redirected to his room. R8 received head to toe assessment. Reddened area found. R2 had med adjustment recently from prior incident. 15-minute checks were implemented. On 7/27/20 at 9:55 AM, V1 stated regarding R2 and R8's incident on 12/27/19, V1 thought R2 was doing better due to the recent medication adjustment on 12/4/19. V1 did not think it was abuse because it was a resident to resident altercation. V1 stated it was too random to be intentional. R2 was placed on 15-minute checks and one on one when out of his room. No behavior modifications were done due to R2's [MEDICAL CONDITION], no interventions were attempted at this time. Because of R2's [MEDICAL CONDITION] the staff was only able to do one on one supervisions. V1 also stated that R2 was frequently combative with staff. The Investigation Notes and Findings dated 12/27/2019 documents: R2 recently had medications adjusted. Based on skin checks, witness interview and resident interview, R2 did strike R8 in the chest with his fist. The attack was unprovoked. c. The 'Final IDPH and/or Abuse Notification' dated 3/19/20, documents the following: R2 was in the dining room with other assisted residents. R2 reached across the table and slapped R8. Staff immediately separated them. R8 received head to toe check. No injuries noted. R2 was placed on 15-minute checks. R2's medications were reviewed. On 7/27/20 at 10:05 AM, V1 stated that she did not think it was abuse as it was not witnessed, R2 and R8 were not at the same table and R2 went to R8's table and slapped her, V1 stated that this was not witnessed by staff. R8's Progress Note, dated 3/19/20 documents: Res (resident) was in dining room waiting for breakfast, it was reported to this staff that another res (R2) hit her (R8), assessed her (R8) for injuries, no injuries noted, res denies c/o's (complaints), separated residents from each other, will mx (Monitor) Handwritten document from V24 (CNA): I witnessed R2 slap R8 in the face over a table around breakfast, serve time around 7AM on Thursday March 19th 2020. The Investigation Notes and Findings Results, dated 3/19/20 documents: Based on resident exam, staff witness, and resident interviews, R2 did hit R8 at the breakfast table. d. R2's MDS (Minimum Data Set), dated 1/31/20, Section C (Cognition) BIMS (Brief Interview Mental Status) score is 6, indicating R2 is severely impaired. Section E 200 (Behaviors) of the MDS indicate resident exhibits physical behaviors symptoms directed toward others such as hitting, kicking, pushing, scratching, and grabbing. R2's Electronic Medical Record's (EMR) [DIAGNOSES REDACTED]. R8's MDS dated [DATE], Section C -BIMS is scored as a 6, indicating R8 is severely impaired. Section E (Behaviors) indicates No Behaviors. R8's EMR [DIAGNOSES REDACTED]. e. R2's Care Plan includes the following focus topics: R2 has impaired cognitive function/dementia or impaired thought processes related to disease Process or other specific disorders of the brain, R2 is considered at risk for abuse/neglect due to poor insight/poor judgment and difficulty communication, R2 has potential to demonstrate physical behaviors. There are no interventions related to each of R2's identified problems on the care plan. On 7/28/20 at 12:50 PM, V4 (Registered Nurse) stated that interacting with R2 was difficult due to his behaviors and his inability to understand. V4 stated that the interventions put in place after a resident to resident altercation was to separate residents, supervise residents while in the dining room, and ensure one on one monitoring during resident's time of increased aggression. V4 also stated that R2 would get angry when confronted after an altercation with another resident and state I will do whatever I want, I will hit who I want to hit, and deny altercations, but marks on the other residents showed that an altercation had occurred. f. On 7/28/20 at 9:55AM, V21 (Registered Nurse) stated that R8 was very afraid of R2, as R2 targeted her. V21 stated she never knew why he was aggressive toward and would hit her. The only interventions we put into place is the one on one supervision when he was in the dining room. R2 was very fast in his wheelchair and he could slip by the nurse's station and enter the dining room where R8 and other residents often stayed. On 7/27/20, V14 (CNA/Certified Nurse Aide), V15 (Housekeeping/Laundry), V16 (CNA), V4 (Registered Nurse), and V17 (CNA) all stated R2 was frequently combative and often targeted R8 while in the dining room. V14 stated that R8 has dementia and cannot defend herself. V17 stated that R8 never provoked R2. 4. The Final IDPH Incident and/or Abuse Notification, dated 4/19/20, documents the following: R2 was in the dining room. R9 was in the dining room. R9 began yelling that he had been hit by R2 on the right side of his face by R2's fist. They were immediately separated and assessed for injuries. No injuries noted. R2 was sent to a behavior center for medication adjustment. On 7/27/20 at 10:00AM, V1 stated that there were no witnesses to the 4/19/20 incident, with R9 stating R2 hit him. R2 was placed on one on one, abuse was not known due to the fact that R9 can provoke other residents. No interventions were put into place since R2 was going to a Behavioral Center for an inpatient stay in just a few days. The Investigation Notes and Findings dated 4/19/20 documents: Per resident interviews and physical evidence, R2 did hit R9. R9's EMR MDS, dated [DATE], Section C- Brief Interview Mental Status is scored a 5, indicating severe impairment. Section E- Behavior documents R9 rejects care and wandering. R9's EMR [DIAGNOSES REDACTED]. .
F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to provide evidence that allegations of abuse were thoroughly investigated and failed to provide protective measures to prevent abuse for 6 of 6 residents (R2, R7, R8, R9, R10 and R11) reviewed for abuse investigations in the sample of 11. Findings include: 1.) The facility's Risk Management form dated 6/13/20 documents under Statement; V11 (Licensed Practical Nurse) stated R10 came into the dining room and was messing with the chairs and R8 moved one of the chairs back. R10 got mad and yelled at R8 and he started hitting his walker against her chair. The facility's form titled, Report of Illinois Department of Public Health dated 6/13/20 documents under, Summary: At 6:00 PM, R10 was being verbally and physically aggressive with R11 over some chairs in the dining room. (referenced above) V20 (Housekeeper), yelled for V11 to come and help because R10 and R11 were fighting. The report documents that when V11 got to the two residents, they were both punching each other in the face and R11 fell on top of R10. When both residents fell , R10 fell on his right side and was screaming, He broke my leg. R11 had his vital signs taken and was helped up to a chair and both residents were taken to a local hospital emergency room for further evaluation. The abuse investigation does not determine or conclude that R10 or R11 willfully harmed or intended to harm, or if abuse was substantiated. R10's Progress Notes dated 6/13/20 documents under Note Text: R10 was in the dining room punching another resident, R11, in the face when V20 called out to V11. During the altercation, while R10 and R11 were swinging at each other R11 fell on top of R10. R10 fell on to his right hip and he started screaming He broke my leg! R10 and R11 were evaluated by V11 and both residents were sent to the local hospital. R10's Progress Notes also document R10 was transferred and admitted to a hospital in a neighboring state for a [MEDICAL CONDITION] hip. R11's Progress Notes document that R11 returned to the facility that evening. R10's Minimum Data Set ((MDS) dated [DATE], Section C documents R10 has severly impaired cognition and severely impaired short term and long term memory. Section E documents behavior of verbal symptoms occurs 1-3 days per week and under physical behavior directed toward others is marked Behavior not exhibited. R10's MDS dated [DATE] documents verbal and physical behaviors not assessed. R10's Care Plan dated 4/23/20, documents under Intervention; Intervene as necessary to protect R10's rights and safety of others. Approach/speak in a calm manner. Divert attention. Remove from situation and take to alternative location as needed. R10's Care Plan dated 1/30/20 documents under Focus; R10 currently has an alteration in his behavior status related to physically agressive behavior and verbally aggressive behavior. R11's MDS dated [DATE], Section C documents R11 has severely impaired cognition and severely impaired short term and long term memory. Section E documents Physical behavior directed toward others occurs 1-3 times per week and Verbal behavioral symptoms directed toward others occurs 1-3 days per week. R11's Care Plan dated 6/4/20 documents under Focus; R11 has the potential to demonstrate episodes of agitation and has the potenial to be physically aggressive. R11's Care Plan dated 3/5/19, documents under Intervention; Intervene before agitation escalates; Guide away from source of distress to a quiet area; Engage calmly in conversation. The facility's Policy and Procedure titled Abuse Prevention and Reporting, dated November 5, 2019, documents under the heading, Policy Statement, The resident has the right to be free from verbal, sexual, physical and mental abuse, corporal punishment and involuntary seclusion. Each resident has the right to be free from abuse. Residents must not be subjected to abuse by anyone, including, but not limited to facility staff,

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F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 4) other residents. On 7/28/20 at 8:30 AM, V2 (Interim Director of Nursing) stated she didn't see the incident/resident altercation between R10 and R11. V2 stated she was told that R10 and R11 were fighting over chairs, and they got into a fist fight that resulted in R10 falling to the floor and fracturing his right hip. V2 stated she isn't sure who hit who first. V2 also stated when R10 started moving the dining room chairs, R8 was also in the dining room and moved one of the chairs back and R10 got really upset and hit her chair with his walker and that's when R10 and R11 got into it. On 7/27/20 at 2:00 PM, V20 stated she was the only employee in the dining room and she saw R10 banging on R8's chair with his walker, then R10 and R11 got into it and started hitting each other in the face with their fists. V20 states she didn't know who hit who first, because she was getting the nurse to come to the dining room. V20 stated that R11 stood up and went up to R10 and both residents were standing during the fight. On 7/28/20 at 4:00 PM, V1 (Administrator) stated she was on vacation when the altercation between R10 and R11 happened, but states she did read the investigation and didn't feel that the altercation was abuse. V1 stated she thought it was more like 2 kids fighting. V1 stated both residents have severely impaired short term and long term memory and both of the residents have a Brief Interview Mental Status of 4. V1 also stated both residents can become verbally and physically agressive. On 7/30/20 at 9:35 AM, V1 stated she was on vacation and didn't fill out the Initial IDPH and/or Abuse Notification form, and she also didn't fill out the Final IDPH Incident and/or Abuse Notification form that determines the conclusions of the investigation. V1 stated the report sent to IDPH by V2 was the Initial and the Final report. 2.) The facility's form titled, Report to Illinois Department of Public Health dated 6/12/20 documents under, Summary: Resident to Resident altercation in their room. Male resident R10 had a broom handle and a pair of scissors and R10 attacked his roommate, R7 while in bed, hitting R7 in the head with the broom handle and scratching his chest with the scissors. Scratches were noted and EMS and local police were called. Resident, R10 was taken to the hospital and R7 was assessed by EMS. Neurological assessments being completed for the next 24 hours. No further distress is noted to R7. The abuse investigation does not include if R10 willfully harmed or intended to harm R7, or if the abuse was substantiated. R7's Progress Notes dated 6/12/20 document, R7 came up to nurses station without any clothes on. V10 (Certified Nurses Aide) went to R7's room to get his clothes, and found R10 sitting on the edge of bed with what appeared to be a large knife and a broom stick. V10 came back up to nurses station to report to V11 (Licensed Practical Nurse) what she saw. V11 went down to resident room with V10 and looked into the opened door to find R10 sitting on edge of bed with broom stick and large knife. V11 asked R10 if he was ok to which he replied that man attacked me. V11 pulled the door closed and went back to the nurses station to call V1 (Administrator) and 911. V11 asked R7 what happened and he said I got in a physical fight. He hit me first. He hit me with a broom in the head. I'm not hurt. R7 had a scrape across his abdomen but did not appear to be in distress. V10 put R7's clothes on and took him to the dining room to eat while the police investigated further. R7 was evaluated by the Emergency Medical Service staff. On 7/22/20 at 10:45 AM, V1 (Administrator) stated R7 and R10 were roommates. V1 stated on 6/12/20, R7 came to the Nurse's Station without any clothing and V10 (Certified Nurses Aide) walked to R7's room to get him clothes and when V10 opened the door, R10 was sitting on his bed holding a broom handle and what V10 thought was a knife. V1 stated R10 told the staff that R7 came into his room through the window when he was asked by the staff if he was alright. The window was shut and had not been opened. V1 stated when the staff asked R7 what happened, R7 told them that he got into a fight and R10 hit him on the head with a broom. V1 stated R10 had a pair of scissors and a broom handle that he got out of the adjoining room. V1 stated they called the police about the resident to resident altercation immediately and R10 was sent out to the hospital for evaluation. V1 also stated R7 was assessed by the emergency medical staff and they continued to monitor R7 for 24 hours and he was fine. V1 stated she notified the doctor, R7 and R10's families, they did an investigation and sent a report in to IDPH. V1 stated R7 was moved to another hall and the incident was added to R7's Care Plan. V1 also stated the room next door to R7 and R10 was unoccupied because V19 (Maintenance) was doing some construction on that room. V1 stated V19 failed to lock the door that was next to R7 and R10's room. R10's Minimum Data Set ((MDS) dated [DATE], Section C documents R10 has severely impaired cognition and severely impaired short term and long term memory and poor communication skills. Section E documents behavior of verbal symptoms occurs 1-3 days per week and under physical behavior directed toward others is marked Behavior not exhibited. R10's MDS dated [DATE] documents verbal and physical behaviors not assessed. R10's Care Plan dated 4/23/20 documents under Intervention; Intervene as necessary to protect R10's rights and safety of others. Approach/speak in a calm manner. Divert attention. Remove from situation and take to alternative location as needed. R10's Care Plan dated 1/30/20 documents under Focus; R10 currently has an alteration in his behavior status related to physically agressive behavior and verbally aggressive behavior. The facility's Policy and Procedure dated November 5, 2015, documents under the heading, Policy Statement, 2nd paragraph; In order to prevent occurences of abuse, this facility will screen potential employees, train all staff, proactively attempt to prevent abuse as required. R10's Progress Notes dated, 6/12/20 at 2:50pm; Transfer to Hospital Note Text: resident was transferred for psychiatric evaluation after incident with another resident. There is no further documentation in R10's medical record/Care Plan to address his physical or verbal aggression toward R7, what interventions they tried and no new interventions added to R10's Care Plan to assure he wouldn't harm others. 3). a) The 'Final IDPH Incident and/or Abuse Notification' dated 12/4/19 documents the following: Another resident R8, was wheeling herself across the dining room. R2 got up from his wheelchair and struck R8 three times in the back and shoulder region. It was a witnessed incident by staff. Staff were unable to get between them to prevent the incident, R2 was unprovoked. R8 received head to toe assessment, no injuries noted at this time. R2 was removed from the dining room and placed on 1 on 1 visual, R2 received a medication adjustment from the Behavioral Center. R8's Progress Note, dated 12/5/19, 12/6/19, and 12/7/19 documents: Continue to monitor bruise to left upper arm. On 7/27/20 at 9:45AM, V1 (Administrator) stated regarding the 12/4/19 incident concerning R2 and R8, that medications were increased for R2, R2 was placed on 1 on 1 supervision and 15 minutes checks to keep all residents safe. V1 did not think that this was abuse because this was R2 and R8's first altercation. V1 stated R2's actions toward R8 were out of the blue and were not provoked by R8. The Investigation Notes and Findings dated 12/4/19, documents the following: Determination: Based on evidence from head to toe check, witness statement, and interviews, (R2) did hit (R8) while in the dining room. There was no factors or evidence that he was provoked in any way. Addendum to final report: Red spot on (R8) shoulder developed into a bruise. The facility was unable to provide documentation to show that a thorough investigation was completed or that effective safety measures were implemented to protect residents from further abuse. The investigation does not include if R2 willfully harmed, intended to harm, or if abuse was substantiated. b) The 'Final IDPH and/or Abuse Notification' dated 12/27/19, documents the following: R8 was wheeling herself into dining room area. R2 stood up from his wheelchair and stumbled over to R8. R2 punched her in the chest without provocation. R2 was redirected to his room. R8 received head to toe assess. Reddened area found. R2 had med adjustment recently from prior incident. 15-minute checks were implemented. R8's Progress Note, dated 12/27/19 documents: On my examination I noted a large red area in the center of her chest. No bruising noted. No other red areas noted. Will continue to observe. On 7/27/20 at 9:55 AM, V1 stated regarding R2 and R8's incident on 12/27/19, V1 thought R2 was doing better due to the recent medication adjustment on 12/4/19. V1 did not think it was abuse because it was a resident to resident altercation. V1 stated it was too random to be intentional. R2 was placed on 15-minute checks and one on one when out of his room. No behavior modifications were done due to R2's [MEDICAL CONDITION], no interventions were attempted at this time. V1 also stated that R2 was frequently combative with staff. The Investigation Notes and Findings dated 12/27/19, documents the following: Findings: (R2) recently had medications adjusted. Based on skin check, witness interview and resident interviews, (R2) did strike (R8) in the chest with his fist. The attack was unprovoked. The facility was unable to provide documentation to show that a thorough investigation was completed or that effective safety measures were implemented to protect residents from further abuse. The investigation does not include if R2 willfully harmed, intended to harm, or if abuse was substantiated. c) The 'Final IDPH and/or Abuse Notification' dated 3/19/20, documents the following: R2 was in the dining room with other assisted residents. R2 reached across the table and slapped R8. Staff immediately separated them. R8 received head to toe check. No injuries noted. R2 was placed on 15-minute checks. R2's medications were reviewed. On 7/27/20 at 10:05AM, V1 stated that she did not think it was abuse. R2 and R8 were not at the same table, R2 went to R8's table and slapped her. This was not witnessed by staff. Handwritten document from V24 (CNA): I witnessed R2 slap R8 in the face over a table around breakfast, serve time around 7AM on Thursday March 19th, 2020. On 7/27/20 at 8:35 AM, V1 stated the incident on 3/19/20 was witnessed by V24 (CNA) but she did not see what caused the incident. The Investigation Notes and Findings dated 3/19/20 documents the following: Results: Based on resident exam, staff witness, and resident interviews, (R2) did hit (R8) at the breakfast table. The facility was unable to provide documentation to show that a thorough investigation was completed or that effective safety measures were implemented to protect resident from further abuse. The investigation does not include if R2 willfully harmed, intended to harm, or if

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 5) abuse was substantiated. On 7/28/20 at 9:55AM, V21 (Registered Nurse) stated that R8 was very afraid of R2 as R2 targeted her. V21 stated she never knew why he was aggressive toward and would hit her. The only interventions we put into place is the one on one supervision when he was in the dining room. R2 was very fast in his wheelchair and he could slip by the nurse's station and enter the dining room where R8 often stayed. On 7/27/20, V14 (CNA/Certified Nurse Aide), V15 (Housekeeping/Laundry), V16 (CNA), V4 (Registered Nurse), and V17 (CNA) all stated R2 was frequently combative and often targeted R8 while in the dining room. V14 stated that R8 has dementia and cannot defend herself. V17 stated that R8 never provoked R2. On 7/27/20 at 8:35 AM, V1 stated that after the incidents on 12/4/19, 12/27/19, 3/19/20, and 4/19/20 the only interventions put in place was one on one supervision and 15-minute checks for R2. The interventions were to monitor R2, not to change his behavior but to keep other residents safe. We could not change his behavior due to the [MEDICAL CONDITION] related to the shotgun wound to his head. V1 stated the one on one supervision and 15-minute checks were usually maintained for 1 or 2 days after these dates. These interventions were put in place to prevent further abuse by R2. 4). The Final IDPH Incident and/or Abuse Notification, dated 4/19/20, documents the following: R2 was in the dining room. R9 was in the dining room. R9 began yelling that he had been hit by R2 on the right side of his face by R2's fist. They were immediately separated and assessed for injuries. No injuries noted. R2 was sent to a behavior center for medication adjustment. On 7/27/20 at 10:00 AM, V1 stated that there were no witnesses, with R9 stating R2 hit me. R2 was placed on one on one, abuse was not known due to the fact that R9 can provoke other residents, no interventions were put into place since R2 was going to a Behavioral Center for an inpatient stay in just a few days. R2 was admitted to the Behavioral Center on 4/21/20. The Investigation Notes and Findings dated 4/19/20 documents the following: Finding: Per res. Interview and physical evidence, (R2) did hit (R9). The facility was unable to provide documentation to show that a thorough investigation was complete or that effective safety measures were implemented to protect resident from further abuse. The investigation does not include if R2 willfully harmed, intended to harm, or if abuse was substantiated. 5. The facility's Policy and Procedure for Abuse Prevention and Report, revised 11/5/19, documents the following: Each resident has the right to be free from abuse, corporal punishment and involuntary seclusion. Residents must not be subjected to abuse by anyone, including, but not limited to facility staff, other residents, .or other individuals. The facility will implement appropriate assessment and care planning tools to identify, correct, and intervene in situations in which abuse, neglect, and/or misappropriation of resident's property is more likely to occur.
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** Based on interview and record review, the facility failed to a.) Store tools used by maintenance in a secured area not accessible to cognitively impaired residents and b.) Failed to supervise cognitively impaired residents for 2 of 2 residents (R7, R10) reviewed for accidents in the sample of 11. Findings include: The facility's form titled, Report to Illinois Department of Public Health dated 6/12/20 documents under, Summary: Resident to Resident altercation in their room. Male resident (R10) had a broom handle and a pair of scissors and (R10) attacked his roommate, (R7) while in bed, hitting (R7) in the head with the broom handle and scratching his chest with the scissors. Scratches were noted and EMS and local police were called. Resident, (R10) was taken to the hospital and (R7) was assessed by EMS. Neurological assessments being completed for the next 24 hours. No further distress is noted to (R7). R7's Progress Notes dated 6/12/20 document, (R7) came up to nurses station without any clothes on. V10 (Certified Nurses Aide) went to (R7's) room to get his clothes, and found (R10) sitting on the edge of bed with what appeared to be a large knife and a broom stick. (V10) came back up to nurses station to report to V11 (Licensed Practical Nurse) what she saw. (V11) went down to resident room with (V10) and looked into the opened door to find (R10) sitting on edge of bed with broom stick and large knife. (V11) asked (R10) if he was ok to which he replied that man attacked me. (V11) pulled the door closed and went back to the nurses station to call V1 (Administrator) and 911. (V11) asked (R7) what happened and he said I got in a physical fight. He hit me first. He hit me with a broom in the head. I'm not hurt. (R7) had a scrape across his abdomen but did not appear to be in distress. (V10) put (R7's) clothes on and took him to the dining room to eat while the police investigated further. (R7) was evaluated by the Emergency Medical Service staff. On 7/27/20 at 9:35 AM, V9 (Regional Maintenance Supervisor) stated that on 6/12/20, V19 (Maintenance), who is no longer employed, received a verbal/written warning about leaving his work area unlocked and V19 was re-educated on keeping vulnerable residents safe. V9 also stated the room next door to R10 was secured on 6/12/20 just after the resident to resident altercation occurred. On 7/22/20 at 10:45 AM, V1 (Administrator) stated R7 and R10 were roommates and states R10 has prejudice for black people. V1 stated on 6/12/20, R7 came to the Nurse's Station without any clothing and V10 (Certified Nurses Aide) walked to R7's room to get him clothes and when V10 opened the door, R10 was sitting on his bed holding a broom handle and what V10 thought was a knife. V1 stated R10 told the staff that R7 came into his room through the window when he was asked by the staff if he was alright. V1 stated when the staff asked R7 what happened, R7 told them that he got into a fight and R10 hit him on the head with a broom. V1 stated R10 had a pair of scissors and a broom handle that he gotten out of the adjoining room. V1 stated they called the police about the resident to resident altercation immediately, and R10 was sent out to the hospital for evaluation. V1 also stated R7 was assessed by the emergency medical staff and they continued to monitor R7 for 24 hours and he was fine. V1 stated she notified the doctor, R7 and R10's families, they did an investigation and sent a report in to IDPH. V1 stated R7 was moved to another hall and the incident was added to R7 and R10's Care Plans.V1 also stated the room next door to R7 and R10 was unoccupied because V19 (Maintenance) was doing some construction on that room. V1 stated V19 failed to lock the door that was next to R7 and R10's room.
F 0745 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide medically-related social services to help each resident achieve the highest possible quality of life.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement individual non-pharmacological interventions, as well as revise the care plan and track behaviors accordingly, resulting in an inability to achieve the highest level of functioning for 1 of 1 residents (R2) reviewed for behaviors in the sample of 11. Findings include: 1. a. R2's Electronic Medical Record's (EMR) [DIAGNOSES REDACTED]. R2's MDS (Minimum Data Set) dated 1/31/20, Section C (Cognition) BIMS (Brief Interview Mental Status) score is 6, indicating R2 is severely impaired. Section E200 (Behaviors) of the MDS indicate resident exhibits Physical Behaviors symptoms directed toward others such as hitting, kicking, pushing, scratching, and grabbing/Verbal Behavioral symptoms directed toward others such as threatening others, screaming at others and cursing at others/Other Behavioral symptoms not directed at others such as physical symptoms such as hitting or scratching self, pacing, rummaging, throwing or smearing food or bodily waste, screaming or disruptive sounds. In the E200 Behavior section is documented as 'Behavior of this type occurred 4-6 days. R2's Care Plan includes the following focus areas: R2 has impaired cognitive function/dementia or impaired thought processes related to disease Process or other specific disorders of the brain, R2 is considered at risk for abuse/neglect due to poor insight/poor judgement and difficulty communicating, R2 has potential to demonstrate physical behaviors. There are no interventions related to each of R2's identified problems on the care plan. R2's Abuse Investigations (see below) and plan for interventions are not included on the care plan. The Psychiatric Evaluation dated 10/11/19 documents: (R2) is a [AGE] year old male He has 2 children but thinks he has 10 children. He has a [MEDICAL CONDITION] from a gun shot wound when he was younger. He has a lot of involuntary movements of his arms and legs. He reports heck no when asked if he has been getting upset. He denies any irritability. He is oriented to self. In this Psychiatric Evaluation, R2 is noted to be confused and needs assistance for mobility. b. The 'Final IDPH Incident and/or Abuse Notification' dated 12/4/19 documents the following: Another resident (R8), was wheeling herself across the dining room. (R2) got up from his wheelchair and struck (R8) three times in the back and shoulder region. It was a witnessed incident by staff. Staff were unable to get between them to prevent the incident, (R2) was unprovoked. (R8) received head to toe assessment, no injuries noted at this time. (R2) was removed from the dining room and placed on 1 on 1 visual, (R2) received a medication adjustment from the Behavioral Center. The 'Final IDPH and/or Abuse Notification' dated 12/27/19, documents the following: (R8) was wheeling herself into dining room area. (R2) stood up from his wheelchair and stumbled over to (R8). (R2) punched her (R8) in the chest without provocation. (R2)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146054	A. BUILDING _____ B. WING _____	**07/29/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GALLATIN MANOR	**900 WEST RACE STREET RIDGWAY, IL 62979**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0745 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 6) was redirected to his room. (R8) received head to toe assess. Reddened area found. (R2) had med adjustment recently from prior incident. 15-minute checks were implemented. The 'Final IDPH and/or Abuse Notification' dated 3/19/20, documents the following: (R2) was in the dining room with other assisted residents. (R2) reached across the table and slapped (R8). Staff immediately separated them. (R8) received head to toe check. No injuries noted. (R2) was placed on 15-minute checks. (R2's) medications were reviewed. The Final IDPH Incident and/or Abuse Notification, dated 4/19/20, documents the following: (R2) was in the dining room. (R9) was in the dining room. (R9) began yelling that he had been hit by (R2) on the right side of his face by (R2's) fist. They were immediately separated and assessed for injuries. No injuries noted. (R2) was sent to a behavior center for medication adjustment. c. On 7/29/20 at 8:35 AM, V1 stated that after the incidents on 12/4/19, 12/27/19, 3/19/20, and 4/19/20 the only interventions put in place was one on one supervision and 15-minute checks for R2 or medication changes . The interventions were to monitor R2, it was not to change his behavior but to keep other residents safe. We could not change his behavior due to the [MEDICAL CONDITION] related to the shotgun wound to his head. The one on one supervision and 15-minute checks were usually maintained for 1 or 2 days after these dates. These interventions were put in place to prevent further abuse by R2. R2 had behaviors 4-6 days of the week. On 7/27/20 at 10:00AM, V1 stated that after the 4/19/20 incident, R2 was placed on one on one supervision, no interventions were put into place since R2 was going to a Behavioral Center for an inpatient stay in just a few days. On 7/28/20 at 12:50 PM, V4 (Registered Nurse) stated that interacting with R2 was difficult due to his behaviors and his inability to understand. V4 stated that the interventions put in place after a resident to resident altercation was to separate residents, supervise residents while in the dining room, and ensure one on one monitoring during resident's time of increased aggression. No behavior modifications were put into place. We do not track behaviors.