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F 226	Continued From page 36 procedures for investigating allegation of abuse, neglect and or misappropriation of property focusing on the need to immediately suspend all employees involved in investigation until investigation concluded. This was completed on 12-13-06. 5. Two employees, E12 and E7, who were involved in the incident have been suspended pending final outcome of the investigation. This was completed on 12-13-06. 6. The facility will conduct an ongoing review and evaluation of the facility's abuse policy and procedure in the monthly Quality Assurance Meeting. This is ongoing with next meeting for 12-21-06.	F 226		
F9999	FINAL OBSERVATIONS Licensure Violations 300.680c)d) 300.1210a) 300.1210b)4)A) 300.3240a)b)e) Section 300.680 Restraints c) Physical restraints shall not be used on a resident for the purpose of discipline or convenience. d) The use of chemical restraints is prohibited. Section 300.1210 General Requirements for Nursing and Personal Care a) The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with	F9999		

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F9999	Continued From page 37 each resident's comprehensive assessment and plan of care. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis: 4) Personal care shall be provided on a 24-hour, seven day a week basis. This shall include, but not be limited to, the following: A) Each resident shall have proper daily personal attention, including skin, nails, hair, and oral hygiene, in addition to treatment ordered by the physician. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the facility administrator. (Section 3-610 of the Act) e) Employee as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that an employee of a long-term care facility is the perpetrator of the abuse, that employee shall immediately be barred from any further contact with residents of the facility, pending the outcome of any further investigation, prosecution or disciplinary action against the employee. (Section 3-611 of the Act) These requirements are not met as evidenced by the following. Based on observation, interview and record	F9999		

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F9999	Continued From page 38 review, the facility staff failed to ensure that one resident (R1) of 4 residents from the sample were not restrained against her will during the trimming of her fingernails. The facility also failed to thoroughly investigate one incident of staff to resident physical abuse to one resident (R1), and the facility failed to follow their established policy and procedure related to resident protection and timely reporting and investigating of all allegations of abuse in a prompt and thorough fashion.. These failures resulted in two staff members that holding the resident's arms down, one staff member standing behind the wheel chair with her arm over the resident's shoulder and around the neck area holding her head back, another staff member straddling the resident's legs in front of the chair to restrain her movements. The resident's lips were observed to be blue in color during the time she was being held. This use of physical restraint by staff members resulted in R1 suffering bruises and skin tears on both of her hands and forearms. In addition, the faiclity also failed to protect residents after the allegation of physical abuse was made by letting staff continue to give resident care; allowed the accused abusers E7 (Maintenance Staff) & E12 (Licensed Practical Nurse) to work their scheduled days from the time the allegation was reported on 12/04/2006 until 12/13/2006 when they were suspended. During this time, E7 and E12 worked throughout the facility completing duties as assigned on both wings of the facility. This failure placed 37 residents at risk of potential physical abuse. Findings Include: 1. Per review of the admission record, R1 is an 81 year old resident admitted to the facility on	F9999		

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F9999	Continued From page 39 3/4/03. Review of R1's current assessment, dated 11/25/06, shows R1 is assessed as a (0) cognitively which indicates that R1 has independent skills for daily decision making. Review of R1's current assessment dated 11/25/06 indicates that R1 is independent for daily decision making, has long and short term memory problems, can make self understood, can understand others and has no behavioral symptoms. Review of the facility accident/incident logs for 07/06 through 12/06, document an alleged abuse on 12/03/206 involving R1. Review of the facility incident report for R1's 12/3/06 incident, which occurred at 12:00 PM, documents the following: "Res (resident) in danger of harming self and others, trying to get out front door. Res brought back in, started trying to bite others, was scratching herself and staff. Was trying to put hands in spokes on chair and feet under wheels to stop chair. Had to hold residents arms to trim nails, was able to get feet away from wheels and move to resident room." A report pertaining to this 12/2/06 incident was sent to Public Health with an alleged physical abuse allegation on 12/4/06. The investigation was sent on 12/5/06 with a result of, "Allegation of abuse unfounded." R1's quarterly assessment, dated 11/25/06, identifies crying and an unpleasant mood in the morning as behaviors for R1. Per nursing notes dated 11-04-06, R1 was started on a smoking program that restricted the times she could smoke to every 2 hours. Prior to the start of the	F9999		

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smoking program R1 could smoke whenever a staff member was available to open the outside door for her. R1 was not able to open the door and propel her wheelchair through it without staff assistance. Nursing notes show R1 became physically and verbally abusive to staff in November after the smoking program was started. R1 also started to frequently say that she was leaving the facility. No physical or verbally abusive behaviors were noted by facility staff prior to the initiation of the smoking program. Per interview with E1(Administrator) on 12-19-06 at 9:30 AM, the smoking program had been initiated because of the frequency that R1 wanted to go out to smoke. E1 said that R1 sometimes forgot that she had just been out to smoke and would want to go right back out. Per E1, staff could not always be available to help her outside. Per record review, R1 signed a smoking policy in July of 2004 that states that "if you are found to be unsafe to smoke unsupervised, you will be placed in a supervised smoking program." Per E1, the facility has not identified any safety issues with R1's smoking. Per review of R1's individual plan of care, dated 11-25-06, neither the smoking program nor the recent maladaptive behaviors are included. There are no staff interventions to attempt when the behaviors occur.

E12 (Licensed Practical Nurse) was interviewed on 12/11/06 at 1:15 PM and confirmed the following. E12 stated that R1 started to scratch E9 (Certified Nurses Aide), and R1 scratched E12 on top of her hand. E12 was unsure if R1 scratched the other CNA's (E8 and E10). An order for Haldol 2 mg was obtained because R1 was verbally and physically abusive to staff and other residents. E12 cut R1's fingernails at the

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F9999	Continued From page 41 nurses station because E12 could not get her to go to her room. CNA's E10 and E8 had towels they put over her arms while they were holding her hands. The towels were placed over R1's lower arms and E10 and E8 held R1's hand while E12 cut her nails. One CNA, E9, stood behind R1. The incident was visible to any staff, residents, or visitors present in the area. Bruises were observed after the incident on R1's bilateral wrist area. An interview was done with a resident who wishes to remain anonymous on 12/11/06 at 2:50 PM. Per this resident, on 12-03-06 at approximately 12:00 PM, "R1 was trying to go out the dining room door to smoke. R1 is on a smoking program every 2 hours but they don't take her unless she throws fits to go out. R1 got mad because staff told R1 she couldn't go out because there was no staff to go with her, they didn't have time and it wasn't time. Staff convinced her if she got her pants changed (R1 was wet with urine) they would take her out to smoke. R1 was mad because staff would not take her out to smoke as they promised her. R1 attempted to go out the door by herself. Staff (E7 Maintenance) put his foot in front of her wheels so she couldn't move and that made her mad. R1 refused to have her pants changed again because they wouldn't let her smoke after she let them change her the last time. E7 pulled R1's wheelchair backwards, away from the door and E8, E10, E9, and E4 held R1's hands down. E7 then pulled R1's wheelchair backwards to the hallway and out of the dining room. The CNA (E9) had her right arm across her left shoulder and around her neck. I heard R1 holler leave me alone."	F9999		

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F9999	Continued From page 42 Interview with a second resident that wishes to remain anonymous, on 12/11/06 at 3:10 PM. The resident said that "he/she observed staff take R1 to her room after R1 had attempted to go out to smoke by herself. E12 E8, E4, E10, E9 and E7 were all involved. R1 was pulled down the hallway backwards by E7, while the other staff were holding her down. They took her to her room and changed her. As the staff were bringing her back up the hall, I heard E12 ask if anyone had fingernail clippers. I heard one of the staff say I don't have fingernail clippers but I have toe nail clippers. E12 said they will be better. E7 was in front of the wheelchair, straddling R1's legs and her holding her arms. The other CNAs were holding her arms and legs. E12 said now you have to hold still and let us cut your fingernails. We're tired of you pinching and scratching us with those fingernails. R1 said let me cut your fingernails like that and let you see how it feels. They were really rough holding her. They held her hands down. They told her if she didn't cooperate they would have to restrain her until they got her nails clipped. Staff told her to shut up they were tired of hearing her holler. I observed her arms approximately 3 to 4 inches above the wrist to the knuckles and they were bruised badly." On 12/12/06 at 8:10 AM, R1 was observed by the surveyor at a local psych unit in the dining room area. R1 was observed with extensive faded yellowish/reddish/blue bruising to the left and right arms approximately 3 inches above the wrist to her knuckles and a skin tear to the left and right arm. R1 said "they cut my fingernails in the hallway by the dining room. Other people were around, but I don't think they paid any attention. I usually kept my nails well shaped and formed."	F9999		

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F9999	Continued From page 43 Interview with Z2 (physician) on 12/12/06 at 9:35 AM. Per Z2, he had been notified within the last week of R1's increased behaviors after a reduction of Alprazolam 0.125mg. three times a day to two times a day. The reduction occurred on 11-01-06. Per Z2, no indication of behavior problems from the facility had been received. I would not expect 4 to 5 people to hold R1 down to cut her nails. That is the worse thing to do. Staff should leave her alone until she calms down. I don't think it would be necessary for staff to cut R1's nails in the hallway with staff, residents and families present. I would expect bruising of the wrist because R1 is on Asprin and Plavix. Z2 said "you don't cut nails when a patient is agitated." Nail cutting is not an emergency and it is not appropriate to cut nails like that. I was not made aware of the situation. Z2 noted that the IM Haldol had been given after cutting her nails. The order was received from the on-call Doctor and not by myself. I think it was a little bit late to give her the Haldol after the nails were cut. The on-call physician told me he had ordered Haldol for her but I was unaware of the fingernail incident. Per interview with E6 (dietary aide), on 12/12/06 at 9:55 AM, on 12/3/06 at approximately 9:00 AM, "R1 was wet and needed to be changed. E7 (Maintenance) blocked the door in the dining room to prevent R1 from going outside. E7 was laughing at her as she tried to go out. R1 then started hitting him in the leg and he kept laughing at her, then he pulled her wheelchair down the hall backwards. The maintenance man laughing at her is what caused her to get upset. At approximately 12:30 PM, I was down the hall and E8 (CNA) had a towel wrapped around R1's right	F9999		

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arm holding her still and E10 (CNA) had a towel wrapped around her left arm trying to hold her still. E9 (CNA) had her arm around R1's neck and her hand on her forehead holding her upright and back in the chair. R1 was telling them to let her go. I noticed R1's lips were a bluish, purple color. I told E10 that R1's lips were turning bluish purple. When I came back up the hall I saw E12 (LPN) in front of the nurses station. E12 told E8, E9 and E10 to let R1 go and that they couldn't be holding her like that up there where anyone could come in and see what was happening."

A third interview was completed with a staff member that wishes to remain anonymous on 12/12/06 at 10:45 AM. Per the staff member, "on 12/3/06 at approximately 9:05 AM, R1 asked me to take her out to smoke. R1 was not wet at that time. I told E9 and she said they were busy so it would be a few minutes before they would take her out. I got a call around 10 to 10:30 AM to come to the dining room. I was told R1 had urinated on the floor. When I went up there E8 was holding the back of R1's wheelchair. E8 said that she wanted to change R1's clothes before they took her out to smoke. R1 was mad and refused. R1 wheeled herself to the front lobby. E8 got in front of her so she couldn't go out the front door. I tried to pull her back but she refused. I heard the girls (CNA'S) say to stop and let them change her pants. I observed that E9, E10, E8 and E7 were there. E7 was pulling R1 backwards in the wheelchair down 100 hall. E8 was on the left side holding her left arm, E9 was on her right side holding her right arm and E10 was in front of her. R1 was kicking at them. E9 kept telling R1, your mom is dead, your dad is dead, your son is dead. E12 came out of her room and told me to keep an eye on R1 so she doesn't go out the side

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doors. R1 wheeled herself out of her room up to the nurses station area. The next time I saw R1, E9 was in back of her holding her back in the chair. E8 was on her left side and E7 was in front of her. E12 was on her right side and had hold of her right hand. Residents and staff were present during the nail cutting. The next thing I knew they had her fingernails cut. R1 was always proud of her nails. They cut her nails at the nurses station (between the nurses station and 100 wing doorway). R1 was cussing and saying you son of bit****, leave me alone. I've never seen her upset like that. E7 was laughing and smiling at her when they were cutting her nails. The next thing I knew they got an order for a shot and gave it to her. It bothered me so bad, I stayed on my wing. I have never observed anything like this. I cannot stand to see anyone mistreated."

A fourth interview was done with a resident that wishes to remain anonymous, on 12/12/06 at 11:35 AM. Per the resident, "it all started with R1 wanting to go outside and smoke. She sees other staff and residents go outside. When she can't go outside it upsets her. When she wants to go out and smoke they won't let her. Then she says she wants to go outside and go home. When the incident took place on 12/3/06 R1 had wet her pants, so they took her and changed her pants. When she came back they refused to let her go out and smoke. They told her her pants were wet again. They took her to her room again, R1 was trying to hit and scratch. They got her in the hallway between the nurses station and 100 wing. All of a sudden I heard E12 say well that's it, your getting your fingernails cut. I heard R1 hollering, turn me loose, oh no you're not, let me go. E8, E10, E12, E7 were present and I think another CNA was present but could not

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remember who. Staff was holding R1's arms and I heard R1's nails being clipped. I have observed E7 laugh at her before. E7 would mock her and laugh."

E2 (DON) was interviewed on 12/12/06 at 1:10 PM. E2 said that E12 (LPN/Charge Nurse) notified her by phone of an incident regarding R1 on 12/3/06 at 12:50 PM. E12 told me she was extremely combative and aggressive, that she was clawing herself and others. E12 said she had notified the on call physician of R1's behaviors and had an order for Haldol. I was not made aware of the nail clipping in the hallway until 12/4/06 (in the morning but uncertain of time). E12 was in my office the next day when she told me and Z1 (RN Consultant nurse) of the incident.

E7 and E12 continued to work their scheduled days from the time of the incident until suspended on 12/13/06. E7 and E12 no longer are employed by the facility. This was verified by E2 on 12/19/06.

E4, E8, E9, and E10 continued to work their scheduled days from the time of the incident and were not suspended. Each were given one to one intensive counseling on 12/13/06 and 12/14/06 as to what constitutes abuse, the right to refuse to participate even if given orders by their supervisor, and how to report suspected abuse. This was verified by E2 on 12/19/06.

The facility Abuse, Neglect and/or Misappropriation of Property Prevention and Reporting Policy-Procedure states under the heading of Protection that "If an employee is suspected of the abuse, suspend the employee(s) pending the outcome of the