STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145597	A. BUILDING _____ B. WING _____	C 03/14/2007

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F 353	Continued From page 10 meal times with cues for activities of daily living.	F 353		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.610a) 300.1210b)3) 300.1210b)6) 300.3240a) 300.3240b) 300.3240f) Section 300.610 Resident Care Policies a)The facility shall have written policies and procedures, governing all services provided by the facility which shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee and representatives of nursing and other services in the facility. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be	F9999		

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F9999	Continued From page 11 made by nursing staff and recorded in the resident's medical record. 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) 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) f) Resident as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that another resident of the long-term care facility is the perpetrator of the abuse, that resident's condition shall be immediately evaluated to determine the most suitable therapy and placement for the resident, considering the safety of that resident as well as the safety of other residents and employees of the facility. (Section 3-612 of the Act) These regulations are not met as evidenced by the following: Based on observations, record review and interviews, the facility failed to have a system in place to closely monitor residents with known aggressive behaviors for 1 of 3 sampled residents (R2). R1 and R2 were involved in a physical altercation. R1 required surgical intervention for a detached retina.	F9999		

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F9999	Continued From page 12 Findings include: R1 was admitted to the Alzheimer's Unit for supervision on 06/06/06 related to Alzheimer's disease per the facility admission record. Hospital record and incident report dated 02/12/07 indicate that R1 had surgery to repair a detached right retina after another resident (R2) had entered R1's room and hit R1 in the right eye. During this investigation on 02/15/07 from 12:30PM to 4:45PM, surveyor interviewed (Administrator), E2 (Direct Care Staff), E3 (Licensed Nursing Staff), E4 (Alzheimer's Unit Coordinator), E5, E6, E7 and E8 (Direct Care Staff). All verified that R1 was injured by R2 on 02/12/07 and R1 required surgery to his right eye after R2 hit R1. E2 through E8 stated that R1 usually did not become physical unless threatened and that R2 had a history of becoming physical with residents and staff on numerous occasions. E4, E5, E6 and E7 stated that R2 had injured R1 in the past and that R2 and R1 are allowed to wander on the unit, but staff is to monitor and intervene or redirect R1 and R2 and other residents if there is a problem. During an interview on 02/15/07 at 4:45PM, E2 (Certified Nurses Aide) provided the following information: E2 was working on the Alzheimer's unit when the incident occurred between R1 and R2. One other staff person was assigned that evening but she was at dinner when the incident occurred. Sixteen residents were present on the unit. E2 walked by R1's room at about 4:00PM and saw R2 on top of R1. R1 was trying to get away from	F9999		

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F9999	Continued From page 13 R2. E2 called E4 (Alzheimer's Unit Coordinator) and asked E4 to come to the unit to R1's room. E4 was able to get R2 off of R1. R1's right eye was slightly red at first, becoming more reddened later. R1 was sent to the emergency room at around 6:30PM. R2 was placed on 15 minute checks the following day. E3 stated that when the incident occurred on 02/12/07 around 4:00PM, E3 was in a meeting and not aware of R1's eye injury until around 6:00PM when E3 stated that R1's right eye was very red and E3 had R1 sent to the emergency room. E3 stated that R1 had to have surgery for a detached retina. E3 stated that two direct care staff were on duty during the incident on 02/12/07. E3 verified that she cares for residents on another wing, but goes to the Alzheimer's unit to pass medications and when needed. E3 stated she was not aware of the incident until after the meeting was over around 6:00PM. E4 (Alzheimer's Unit Coordinator) stated on 02/15/07 at 12:45PM, that she heard a noise and found R2 was on top of R1 and helped to get R2 out of R1's room. E4 stated that residents are allowed to wander the unit because it is a closed unit and staff intervene when occurrences happen. E4 stated neither R1 nor R2 were on 15 minute checks or one-to-one monitoring at the time of the 02/12/07 incident. E4 confirmed that R2 was not placed on 15 minute checks until 2/13/07. E4 verified that R1 remained in the hospital on 02/15/07 recovering from surgery to repair the detached retina. E5 (Certified Nurses Aide) stated on 02/15/07 at 1:00PM that R1 usually likes to stay in his room and not be bothered and that R1 usually does not	F9999		

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F9999	Continued From page 14 get agitated unless someone bothers him. E5 verified that R2 goes into other residents' rooms often. E8 stated on 02/15/07 at 1:30PM that 15 minute checks are done when there is an incident otherwise they just try to check on residents and keep residents busy. E8 stated that R2 did not have 15 minutes checks prior to the incident on 02/12/07. Z1 stated on 02/15/07 at 3:30PM that R1 had a trauma to the left eye from where another resident had hit him in the eye resulting in a detached retina and requiring surgery. Z1 stated that there was also evidence of a previous trauma that showed in the eye exam. On 02/15/07 at 12:20PM surveyor observed one staff person (E8) on the unit in the Alzheimer's dining room. There were 15 residents on the Alzheimer unit. During this time surveyor observed R3 (female peer) sitting in a chair that was next to R2's bed in R2's room. R2 was in the bed asleep. R3 seemed anxious and was rocking back and forth in the chair. E4 entered the unit at this time and surveyor pointed out to her that R3 was in R2's room and E4 redirected R3 out of the room. Other residents were in the sitting room or in their rooms except for two wanderers who go up and down hall and into other peers' rooms. After surveyors arrived to the unit on 02/15/07 at noon, E6 (Certified Aide) entered the unit to work. E6 verified that she was working on another unit and was pulled to come to the Alzheimer's unit to work. E6 stated that she was originally scheduled to work this morning on the Alzheimer's unit but had been pulled to work on the other wing that was short.	F9999		

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F9999	Continued From page 15 Review of a hospital record dated 02/12/07 documents R1 had an abrasion to the left shoulder, multiple bruises all over body, and an injury to the right eye resulting in admitting R1 to the hospital and having surgery to repair a right detached retina. R1's care plan dated 06/06/06 through 12/14/06 documents that R1 has a history of verbal and physical abuse to peers. Interventions instruct staff to redirect R1, monitor surroundings for possible triggers, and place a caution sign on the outside of R1's room door. Also, this care plan notes where R1 was pushed to the floor on 11/19/07 by R2 and that R2 hit R1 on 12/01/07 resulting in 2 large skin tears on the right inner arm. According to incident reports, interviews on 02/15/07 from 12:30 to 4:45PM, and R1 and R2's care plan, R1 had altercations occur with R2 or by R2 approximately 5 to 6 times that is recorded. In December, 2006, R1 was sent into the hospital for problems with a red eye and was given antibiotic. R2's care plan shows several incidents of R2 being physically abusive and causing R1 to become upset. On 11/08/07 R2 pushed R1 against the wall and punched him. On 11/22/06 hit another peer. On 12/01/06, R2 became upset with R1 and both R1 and R2 started to hit at each other. On 12/10/06, R2 became upset with a staff person and hit the staff person. On 12/13/07, R2 grabbed R1 causing two 2 large skin tears and on 12/08/07, R2 grabbed another residents' walker causing the peer to fall. On 12/25/07 hit a direct care staff person on the	F9999		

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F9999	Continued From page 16 back. On 01/03/07, R2 went into a male peer's room that was sleeping and began hitting peer with shoe and with fist. On 1/10/07 R2 was trying to force his way into another peers' room when a family member tried to tell R2 he was in the wrong room and R2 became agitated and drew back his fists threatening to hit the family member and cursed them. On 01/14/07, swing fists at peers and was difficult to redirect. On 02/05/07, R2 wanted to leave and "punched the direct care staff person in the face three times, punched direct care staff's chest and smacked the direct care staff person across the neck." On 02/12/07, R2 had hit male peer (R1) in the right eye causing redness to the right eye and chin. R2's care plan says to monitor closely when around other peers and to intervene when necessary. R2's care plan does not address closer monitoring such as one-to-one monitoring or frequent checks and, according to interviews done on 02/15/07 with E2 through E8, R2 had not been on 15 minute checks or one-to-one with staff before 2/13/07. E5, E6, E7 and E8 verified during interviews on 02/15/07 that there are three direct care staff scheduled to work the Alzheimer unit but that there are usually only two direct care because a lot of time the 3rd direct care staff person is pulled off to another unit to work. During breaks and meal times there is one staff person on the unit, the Alzheimer coordinator (during the week days) and the nurse who comes to the unit to	F9999		