STATE OF ILLINOIS
DEPARTMENT OF PUBLIC HEALTH
STATEMENT OF VIOLATIONS AND PLAN OF CORRECTION

GILMAN HEALTHCARE CENTER	0049981
Facility Name	I.D. Number
1390 SOUTH CRESCENT STREET, GILMAN, ILLINOIS 60938	
Address, City, State, Zip	
02630	AUGUST 7, 2008
Reviewed By	Date of Survey
ANNUAL LICENSURE	02462, 02522, 26409, 13108, 15407, 02616, 02544, 25071
Type of Survey	Surveyed By

As a result of a survey conducted by representative(s) of the department, it has been determined the following violations occurred.

IMPORTANT NOTICE: THE STATE AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED UNDER PUBLIC ACT 83-1530. DISCLOSURE OF THIS INFORMATION IS MANDATORY. THE FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

"A" VIOLATION(S):

300.610a)
300.682a)2)
300.682a)4)
300.690c)
300.1210a)
300.1210b)3)
300.1210b)6)
300.1220b)2)
300.1220b)3)
300.2210b)5)

Section 300.610 Resident Care Policies

a) The facility shall have written policies and procedures, governing all services provided by the facility. These policies shall be in compliance with the Act and all rules promulgated thereunder. These policies shall be followed in operating the facility.

Section 300.682 Non Emergency Use of Physical Restraints

a) Physical restraints shall only be used when required to treat the resident's medical symptoms or as a therapeutic intervention, as ordered by a physician, and based on:

2) the assessment of a specific physical condition or medical treatment that requires the use of physical restraints, and how the use of physical restraints will assist the resident in reaching his or her highest practicable physical, mental or psychosocial well being.

4) a demonstration by the care planning process that using a physical restraint as a therapeutic intervention will promote the care and services necessary for the resident to attain or maintain the highest practicable physical, mental or psychosocial well being. (Section 2-106(c) of the Act)

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Section 300.690 Serious Incidents and Accidents

c) The facility shall maintain a file of all written reports of serious incidents or accidents involving residents.

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 psychosocial well-being of the resident, in accordance with 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 days 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 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 300.1220 Supervision of Nursing Services

b) The DON shall supervise and oversee the nursing services of the facility, including:

2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy.

3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be

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accomplished, physician's orders, and personal care and nursing needs. Personnel representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition.

Section 300.2210 Maintenance

b) Each facility shall:

5) Maintain all furniture and furnishings in a clean, attractive, and safely repaired condition.

These requirements are not met as evidenced by:

A. Based on observation, record review and interview the facility failed to recognize a potential hazard to one of two sampled residents (R1) who were utilizing full siderails as a physical restraint while in bed which put R1 at risk of severe injury due to repeated behaviors of throwing feet and legs over the side rails of the bed, scooting to the end of the bed and leaning over the siderails. R1 was also able to physically pull the full siderails and rail pads completely off the bed which resulted in R1 falling out of bed onto the rails. The facility failed to recognize the potential risk to R1 and failed to reassess the use of siderails prior to or after the fall for alternatives to the high bed with full side rails.

B. Based on observation, record review and interview the facility failed to investigate falls for one of three sampled (R1) residents utilizing wheelchair lap trays. The facility failed to recognize safety hazards for (R1) who had fallen after removing the lap tray on three different occasions. R1 received a laceration above the eye with each fall. The facility failed to reassess R1's wheelchair seating and restraint use to identify approaches and modifications to protect R1 from future injury.

Findings include:

1. R1's July 2008 Physician's Order Sheet (POS) lists an initial admission date of 2/22/08. R1 was admitted to the facility following a month and a half (1/09/08-2/22/08) hospitalization. The POS lists R1's age as 52 years old and lists diagnoses which include: Mental Retardation (Severe), Gastrostomy, Seizure Disorder, Hydrocephalus, Arthritis, Megacolon, Dysphagia, Hypertension,

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Osteoporosis and Benign Prostatic Hypertrophy (BPH). The hospital history and physical dated 1/09/08 identified that R1's family reported that R1 was ambulatory approximately a year ago, but because of repeated knee infections, became less and less mobile and has been in bed and wheelchair bound since. R1 has been living in a facility for residents with developmental disabilities most his adult life and had a history of self destructive behaviors including repetitive movements with hitting head against the wall and hitting his hands and extremities against any hard surface. While in the hospital, R1 received a new ileostomy. R1 also experienced a 24 pound weight loss and a gastrostomy tube was placed in February 2008. The hospital recommendations were for R1 to be transferred to a nursing home until the nutritional needs and physical condition improved. The Physician stated in the consultation report "As (R1) improves his self destructive behaviors will return and they may need to gradually increase the Seroquel to its previous dosage." The assessment stated "(R1's) disability is profound and physical therapy is imperative for improving his current status." The palliative care goals included PT/OT (Physical Therapy/Occupational Therapy) for strength, ROM (Range of Motion) and getting resident up in a wheelchair daily, and to return to toileting privately which he liked to do.

2. R1's quarterly MDS (Minimum Data Set) dated 6/19/08 identified R1 with long and short term memory problems and severe cognitive impairment. R1 is assessed with behaviors that include easily distracted, restless, mental function varies, rarely understands, repetitive physical movements, physically abusive behavior, socially inappropriate behavior, and resists care on a daily basis. The assessment identifies R1 as needing extensive assist of two for bed mobility and for transferring from bed to chair. R1 is assessed as having no sitting or standing balance ability. R1 height was documented as 74 inches and weight was 166 pounds. R1 has a physician order dated 3/20/08 for padded rails to bed and for lap tray while in wheelchair. The 6/19/08 quarterly assessment and the 3/31/08 admission assessment documents that R1 has had no falls in the last 0-180 days during both time periods, however there is a documented fall from bed on 5/09/08, and documented falls from the wheelchair on 4/19/08 and 3/31/08 that are not captured in this assessment. R1's restraints and devices listed were full bed rails and a chair that prevents rising. R1 has a Physician's order dated 6/07/08 for an antipsychotic medication, Seroquel 400 mg tablet at bedtime and an antianxiety medication Ativan .5 mg every 8 hours as needed for restlessness and agitation.

Observations:

1. R1 was initially observed in his room during the entrance tour of the facility on 7/09/08 at 9:50 am. R1 was seated in a high backed wheelchair with anti-tip bars and had a wooden lap tray restraint with a seatbelt that secured the lap tray in the back. R1 would reach out to the staff and and flail arms in response to staff. R1's bed had two full length bed rails attached to a regular height bed with long padded bumpers.

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2. On 7/10/08 at 1:20 pm R1 was observed asleep in bed with the covers over his head. There were two full length metal side rails up on each side of the bed, however no rail pads were observed in use on the bed.

3. On 7/10/08 at 4:20 pm R1 was observed in the bed with two padded side rails in place. When the surveyor knocked on the door and entered the room R1 sat straight up in bed and started reaching out for the rails and the surveyor, the resident had removed his brief and had thrown it on the floor, R1 seemed agitated was pulling on side rails and was laying back and would bring legs and feet up on the top of the side rail and back down. R1 was tall when he sat up in the bed and could lean way over the side rail to reach out. The resident call light was activated by the surveyor and after a interval of approximately five minutes a Certified Nurse Aide assisted R1 with incontinence care.

4. On 7/11/08 approximately 3:15 pm R1 was again observed in his bed with the full padded side rails. When R1 became aware that someone was present, he sat straight up in bed and immediately started leaning over the side rails on each side to reach out and grab surveyors and was pulling on the rails. Two CNAs were in the hallway outside of R1's room. When questioned, they confirmed that R1 does sit up in bed, is very strong and sometimes does get his legs over the siderails when he is ready to get up. They stated they have not seen him get all the way out of the bed but they thought he was capable of accidentally going over the bedrails. The facility Owner, E1 and Director of Nurses, E3 were informed of the observations on 7/11/08 at approximately 3:30 pm at the daily status meeting, of a strong concern that R1 was physically capable of accidentally falling over the side rails.

5. On 7/14/08 at 9:00 am R1 was observed seated in his wheelchair in his bedroom with the wooden lap tray with padded sides affixed to the wheelchair. The wheelchair had anti tip supports mounted to the back of the chair. When R1 was awake during the day and was in the wheelchair, R1 would reach way out with arms towards staff. He would push the chair backwards with his feet and bump into door frames.

6. R1 was fed in the assisted feeding dining room on 7/14/08 at 12 noon -12:20 pm with Certified Nurse Aide (CNA) E20 sitting directly in front of him with the lap tray in place. R1's lap tray was not removed during the one to one assistance even though R1 was not displaying any behaviors during the meal.

7. R1 was observed alone in his room while up in the wheelchair with the lap tray with the TV on 7/14/08 at 12:30 pm and at 12:45 pm. R1 was later observed in a low bed from 1:15 pm, and 2:15 pm and was back up in the wheelchair with the tray in place at 4:00 pm in his room. The resident would make noises and would reach toward the floor or over to the bed and would hold onto the lap tray and pull on it while seated in the room. The nurse call cord from the wall was clipped onto the resident's wheelchair. One wheel was locked on the chair. R1 was constantly moving around in the chair.

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8. On 7/14/08 at 4:45 pm it was noted that R1 was in the room with the lap tray on the wheelchair. The lap tray looked like it was on at an angle. R1 would lean way over the side toward the floor with his arms. Certified Nurse Aide, E12 came into the room that R1 was in. When questioned about the angle of the tray, CNA, E12 responded "(R1) works at the tray to get it off, it's supposed to connect at the sides to the wheelchair armrests. He will wiggle it and work it loose." It was noted that one of the armrests that the tray was attached to had a stripped screw that had pulled loose from the frame which made the armrest bend at an angle. The tray was attached in the back with a seat belt type closure. E12 stated that R1 has not tipped the wheelchair over sideways that she was aware of. E12 stated that R1 can stand to transfer and can walk with two staff assisting. E12 brought R1 up to the dining room and reported the loose screw to the nurse at the desk.
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Restorative Aide E13 was interviewed on 7/10/08 at 4:45 pm. E13 stated that they work with R1 on wheelchair positioning, range of motion and feeding. E13 stated they have not been working on bed mobility and had not tried a low bed for R1. E13 stated "Sometimes he gets a leg over the rails, he is all over the place, and he is so tall a low bed might not fit him."

Restorative CNA, E13 was interviewed about R1's wheelchair positioning and safety on 7/15/08 at 9:20 am. E13 stated "We have always had issues with bed positioning and wheel chair positioning for (R1). He can follow some commands. I heard the nurses talking about what we can do to keep him safe in the bed and the wheelchair about a month ago. He is scary to keep safe, but he has come a long way. E13 stated that she takes information from the staff and we know he has poor safety judgment. He calls the midnight nurse by name and he is always hungry. E13 stated there are times when R1 gets leaned over so far sideways that we are afraid he will tip over. E13 stated they intervene and cue R1 to sit up straight and put his hands on the tray. E13 stated the therapy company that was here before set up the current wheelchair that he is using."

A facility incident report reviewed on 7/11/08, dated 5/09/08 1:25 am documented "Resident resting in bed is restless. Grabbed full side rail along with the bumper pad. Physically pulled off and then it fell to the floor with bumper pad upon it. Resident fell (rolled out) and landed on top of bumper pad on R (Right) side and received (approximate) three cm (centimeter) scratch to L (left) ankle lateral side/ L (left) shoulder very little swelling...Transfer of (three) back to bed. Tabs (alarm) unit in place. Locks to top of rails to attach siderails were not originally in place. Now locked and FOB (foot of bed) elevated. PRN (as needed) Tylenol and Ativan given." This entry was documented by Licensed Practical Nurse (LPN) E14. The follow up documented on the 5/09/08 incident report stated, "Bed inspected by maintenance dept (department) -No safety concerns." The incident report indicated that it had been reviewed by the safety committee.

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R1's bed was inspected with Maintenance Director, E10 on 7/11/08 at 1:10 pm. R1 was not in the bed at the time. E10 stated that he did not remember this specific incident or checking the bed rails afterwards. E10 demonstrated that there is a locking tab on each corner post for the full bed rail that when in the open position allows for the bed rail to be removed and when in the closed locked position it secures the rail in place. The tabs were locked and in place and the bedrails were secure when pulled up on. The bed height with the rails was approximately four feet above the floor.

Nurses notes dated 7/11/08 3-11pm document "Pt (patient) agitated early throwing legs up over siderails, pulling colostomy bag off, throwing bag onto wall. Pulling off attends, throwing that off, hitting staff, grabbing at staff. PRN meds given for (increased) anxiety, better later in the shift. Pt placed in (low) beds this shift for first time, No difference noted at present Pads on floor beside bed to prevent injury."

7/12/08 3 pm-7am documents "No behaviors noted slept well" and 7/13/08 3 pm-7 am "No behaviors noted slept well."

R1's initial Siderail Assessment dated 3/06/08 lists R1's cognitive status as confused and unable to follow directions and has motor agitation. Communication ability is listed as; doesn't make needs known and unable to use the call light. The medical/functional symptoms for the use of protective devices has a check mark for psychotropic medications and poor body control. Environmental changes are documented as padded side rails on bed. The assessment documents "unknown" for alternatives tried including type and duration of trial period and resident response. The assessment did not identify any potential negative factors to device use. There were ten potential probes to address, none were selected. The assessment marks that benefits (of the siderail use) outweigh the negative. The assessment identifies the side rails as a restraint. The Device parameters list padded side rails when up in bed related to seizure disorder and self abusive movement. The next quarterly update dated 3/31/08 (25 days after initial) does not discuss the resident's response to side rail use. It just documents padded rails up when in bed, continue with current plan of care. There was no documentation to discuss the resident's acceptance or any complications. There was no quarterly review of the side rail assessment to coincide with the 6/19/08 quarterly care plan assessment.

The quarterly restraint assessment/effectiveness report completed by Registered Nurse (RN) E7 on 4/02/08 lists the reason for the full padded side rails in bed as seizure disorder. It documents there is no resident response to the restraint and no attempts to use less restrictive measures. It states that no complications related to physical restraints have been noted.

NURSES' NOTES:

R1's Nurses notes reviewed from admission on 2/22/08 through 7/14/08 do not reflect

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any seizure activity for R1. Nurses Notes do document at least ten incidents of R1 displaying agitation while in bed and attempting to throw legs over side rails in bed, scooting to the end of the bed, or removing rail pads prior to the 5/09/08 fall from bed and at least three times after the fall. Examples include;

3/21/08 11-7 "Alert res very wild slapping bumpers throwing bumpers off of bed. Grabbed pump and threw it to the floor..."

3/23/08 3p-7a "Alert non verbal res down for afternoon nap had legs over rail swinging legs..."

3/28/08 "Alert resident very agitated all over bed yelling out checked on frequently. around 2 am resident yelling, found resident with head hanging off of bed, bumper pads thrown across room, yelling out, resident repositioned x (times) 3 people and res gotten up and into wheelchair ..Fed pudding, sherbet and health shake..."

3/29/08 11-7a "Res sleeping until 4 am then resident kicking tore colostomy bag off ...res then kicked bedrail and broke it. Resident up in wheelchair out in TV area for observation..."

4/02/08 11p-7a "Very restless....Ativan and Tylenol given for general discomfort and restlessness...Continues to turn around and sleep with head toward foot of bed, ...bumper pads in place but resident throwing legs over..."

4/09/08 11p-7a "Resident combative and restless, PRN given with little effectiveness...up in wheelchair with lap tray. Resident taking hand and thrashing around pushing wheelchair backwards...while in bed had cushioned bumper pads in place, throwing legs over side..."

4/19/08 11-7 "Alert resident very restless, yelling slapping bumper pads and mattress trying to flip legs out of bed. Resident given PRN meds with slight relief....res continues to pull out tubing from feeding. Resident very agitated."

4/20/08 3 p-7a "Yelling and slapping at bumpers trying to pull them off, checked on frequently...continues to yell out till sleeping off and on..."

4/26/08 3p-7a "Thrashing and in bed, legs over rail pads...."

4/26/08 3p-7a "Put to bed with bumper pads in place was very energetic and sitting toward end (foot of bed)."

5/02/08 11-7 "Resident awake and banging on rails pulled bumper pads off and threw them across the room...."

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5/06/08 2:30 am "Scooted to foot of bed, feet hanging over foot of bed numerous times, was put in his wheelchair in TV area for safety and monitoring. Very active, banging at bed rails, slapping walls prior to being gotten up."

5/09/08 11p-7am "Resident is resting in bed. Is restless, grabbed full side rail along with bumper pad. Physically pulled off and then it fell to the floor with bumper pad on top of it. Resident fell (rolled out) and landed on top of the bumper pad on right side and an approximate 3 cm long scratch to left ankle (lateral side) L (left) shoulder very little swelling. Transfer of (three) back to bed tabs unit in place. Locks to top of rails (siderails) were not originally locked...Now locked and FOB (foot of bed) elevated...PRN Tylenol and Ativan given ...will monitor."

Nurses Notes document R1's continued agitation in bed after the fall in the following examples:

5/13/08 3 p-7 a "Resident found at supper time leaning over w/c (wheelchair) practically hanging self aide yelled for help res repositioned per nurse and aide res wild slapping walls, pulling at staff, resident given meds with no relief, when in bed resident pulling on bumper pads, pulled off pull up and colostomy."

5/27/08 11 p-7 a "Sitting up and scooting to foot of bed, staff monitoring frequently ...assisting him up in bed."

7/04/08 11-7 "Resident yelling out...saw residents arm come around the door frame. Resident was sitting at foot of bed when hearing this writer res layed himself down and pulled covers over face...resident proceeded to slap at writer then point at mouth making gestures of feed me."

7/08/08 7-3 "No behaviors except at 2:30 pm res was ready to go in wheelchair and had legs over rail...Up in wheelchair no further incident."

R1's nurse's notes dated 3/31/08 7-3 document "Alert very restless (up) in w/c (wheelchair) with lap tray on banging into walls, grabbing at staff and peers. Sliding down in w/c repositioned several times per staff, approximately 5 seconds after repositioning, staff observed resident lunging forward, pulling tray off, strapping...Res fell to floor laceration noted above right eye. Bleeding much...tray bloody nose unknown if bleeding from ears. Ambulance called, mother, POA (Power of Attorney) called." 3/31/08 11-7 shift "Pt returned 4 pm ...5 sutures to brow line."

Additional Nurses notes document R1's restless behavior when in the w/c with lap tray, including two additional falls and additional behaviors of physically breaking the equipment.

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Examples include:

4/01/08 "Uncooperative with assessment continues to slide down frequently. New pommel cushion placed in wheelchair with non skid padding on top of that."

4/16/08 7-3 "Alert restless sliding down in w/c various times, each time being repositioned. Banging hands on tray, walls and staff."

4/19/08 3 pm-7am "Alert up in w/c all over N.H. (Nursing Home) Color pale...restless but fed snack started to calm but res pushing on lap tray moving it around. 1:1 (One to one) with slight success...resident given PRN meds with no relief...Res going up and down hallways kept in sight of staff at 5 pm res in dining room this writer heard tray hit floor went down and res was on floor falling on lap tray res popped open previous incision site bleeding noted...Dr. (doctor) called, Dr. returned paging, explained incident-Dr. increased Seroquel to 50 mg bid."

5/13/08 3 pm-7 am."Resident found at supper time leaning over w/c practically hanging self, aide yelled for help res repositioned per nurse and aide res wild slapping walls, pulling at staff, resident given meds with no relief, when in bed resident pulling on bumper pads."

5/18/08 3 pm-7 am "Res had broken 2 wheelchair nuts and bolt out of 1st chair and about hung himself with other and tray broke and arm (rest)...resident then given other wheelchair."

6/19/08 Days "Res broke large wheel off of w/c. Chair taken to shop for weld repairs."

6/24/08 "5:45 pm Res (Resident) found on floor of room by staff. 1 inch laceration noted to L (Left) temporal area- minimal amount bleeding-steri strips applied."
Per interview with E21 LPN on 7/15/08 at 1:10 pm. The fall of 6/24/08 occurred in the bedroom when R1 fell from his wheelchair, E21 stated she did not know how R1 removed the lap tray as it wasn't broken.

7/09/08 7am-3pm "Res loud this am yelling out 'Hi' at all passersby and smacking lap tray with hands also swinging at staff."

CARE PLAN:
R1's care plan which was dated 4/01/08 and was last reviewed 6/25/08 by the care plan team, documents; "Resident requires use of lap tray to w/c (wheelchair) and padded side rails to bed. Restraint (E.G. trunk/limb) DT (due to) to voluntary and involuntary movements that place resident in danger of falls. The goal listed was "Time spent in lap tray restraint will be reduced by next assessment date." The approaches include; #6 reassess need for restraints quarterly and PRN (as needed).

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The care plan does not address any attempts by R1 to remove the lap tray from the wheelchair, or the three falls that resulted in injury when R1 removed the lap tray.

There was no goal in the care plan for the use of the padded side rails. The care plan did not address goals for the use of side rails as restraints in view of R1's frequent restless behaviors in response to hunger, or discomfort from gastrostomy tube site or colostomy, attempts to scoot to the end of the bed, throw legs over the padded rails, pulling bumper pads loose and attempt to remove side rails or the actual fall from bed that puts R1 at risk of severe injury.

LPN, E14 was interviewed by telephone on 7/15/08 at 9:25 am. E14 confirmed that she had been working on 5/09/08 on the second shift when R1 had removed the siderail and had fallen from bed. E14 stated that R1 is a strong man. E14 stated that the little tabs on the siderails were not locked. E14 stated that she always does a visual check of R1 on her rounds and usually checks that the tabs were locked but that she did not catch it that night. E14 stated that she did not think that R1 could specifically try to unlock the tabs himself. E14 stated the tabs could have popped open if R1 pulled hard enough on the rail.

There was no follow up investigation provided by the facility. The 5/09/08 incident report stated that the bed was checked by maintenance and no safety issues were identified. There was no reassessment of the use of the side rail restraints after R1's fall per interview with RN, E7 on 7/16/08 at 10:30 am. E7 stated she was not aware R1's fall from bed on 5/09/08.

LPN, E15 was interviewed on 7/14/08 at 4:15 pm. E15 stated R1 would put legs over the side rails and times and would scoot to the end of the bed. E15 stated they would reposition him. E15 stated when R1 gets excited his hands start flailing, a lot of times the behavior was when he was hungry. E15 stated the G tube is totally out and R1 is often hungry they often request double portions at supper. E15 stated that R1 wants attention and is not deliberately trying to get out of the bed himself.

CNA, E12 was interviewed on 7/14/08 at 4:40 pm E12 stated R1 was still trying to get out of the low bed but she felt (R1) was safer than in a high bed. E12 stated she did not recall (R1) having any previous falls from bed on her shift but indicated that R1's "wildest times are between 4:30 pm and 5:00 pm when he wants to get up." E12 stated that when R1 hears any type of noise in the hallway he's up and trying to get out of the bed. E12 stated we automatically go down there to calm him and give him ice cream or pudding. E12 stated that it had been suggested by the CNAs a lot that he needed a low bed, they would tell the nurses and the nurses should report to the Director of Nurses, but it takes awhile for them to do assessments. E12 stated usually after a couple of falls, high risk residents would get a low bed. E12 stated that R1 can sit straight up in bed and can stand for transfers and can also walk short distances with the assistance of two staff. E12

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reported that R1 has hit out and swings his arms but that is his way of showing love and is not meaning to hit.

On 7/15/08 at 12 Noon Director of Nurses, E3, was shown R1's incomplete physical restraint assessment dated 4/02/08 and the siderail assessment dated 3/31/08. The assessments lacked any documentation related to R1's fall from the bed after removing the siderail and the numerous attempts both prior to and after the incident to throw legs over side rail, remove bed bumpers, and falls from the wheelchair after removing the wheelchair lap tray on 3/31/08 and 4/19/08 and 6/24/08. E3 was asked if there were any incident reports or fall investigations for these incidents. E3 stated she couldn't find any. E3 stated that E7 and E11 work on the fall assessments together and the behaviors and incidents should have been included in the assessments and should been investigated and should have been discussed and included in the careplan for R1. E3 stated that R1 was difficult to take care of with his constant movement and in hindsight should have been moved to a low bed sooner. E3 said staff were aware of (R1's) constant movement but did not think they were in fear of (R1's) safety. E3 stated "It has been a top priority even before (the survey team) came in for the survey to get a really good fall prevention program in place."

On 7/15/08 at 3:15 pm Director of Nurses (DON), E3 was asked if there had been any wheelchair seating assessments conducted by the therapy department for R1, after any of the incidents when R1 had removed the lap tray and fallen. E3 stated that (R1) has had a couple of different chairs; his has his name on it. E3 said Therapy should have assessed it. It would be in the therapy section of the chart.

R1's therapy weekly progress notes for the period of 2/28/08-3/05/08 documented “Pt (Patient) seen for wc (wheelchair) positioning to provide appropriate seating for the resident when out of room for socialization and staff supported mobility around the facility." The short term goal was for the "res (resident) to retain centered posture in w/c with rigid trunk support, head support, 3 inch wedge cushion under a gel seat with firm attachment to the w/c for 1 hour." The positive indicator for the goal was described as “Pt. (patient) has displayed appropriate seating posture in wheel chair for 2-3 hours."

The long term goal was "Resident will retain intact skin, centered posture in wheelchair with above adaptations for 3 hours. May utilize the lap tray for to improve participation in stimulation tasks." The report was signed by the therapist on 3/17/08. There were no additional therapy notes or evaluations of R1's wheelchair seating after that date.
It was noted during random observations made of R1 on 7/08-7/15/08 that R1's current wheelchair did not have rigid lateral supports, a head support, or a gel cushion. R1 had a high back on the wheelchair that stops at the shoulders. There were no lateral supports in the wheelchair. The cushion in the chair was a worn pommel style cushion. There was no gel cushion on the chair.

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On 7/15/08 at 5:00 pm CNA, E12 and CNA, E19 attempted to get R1 to stand up from the wheelchair to ambulate a short distance. R1 was uncooperative at the time. The staff was questioned about the safety of the current wooden lap tray that R1 uses. E12 stated that (R1's) chair broke about two months ago and they had to have it welded. (R1) used to have a molded clear plastic table top tray on the wheelchair however he broke it off. E12 stated she felt the current tray, which she believed used to belong to another resident, fits better on the wheel chair. E12 stated (R1) used to lift up on the previous clear plastic tray. E12 was asked about the seat belt release for the lap tray that is in the back of the chair, and incidents of R1 removing the tray. E12 stated "(R1) can twist around and get his hand behind the back of the chair and push the button (to release the tray) but we usually get to him before he does that."

R1's last physical restraint assessment completed by Registered Nurse (RN), E7, dated 4/02/08 documents lap tray in w/c as the type of restraint. The reason for the restraint is listed as postural support. The assessment asks for a description of response to the use of physical restraint and attempts made since last assessment to use least restrictive measure. The response documented to both questions was "None." The restraint assessment stated that no complications related to restraint use has been noted. The assessment does not discuss any of the behaviors described in the nurses notes relating to R1 being agitated with the tray, physically removing tray or falling from the wheelchair on three occasions. E7's recommendations for the next 90 days included "Continue to use the lap tray... The lap tray helps with resident's postural support while being up in chair."

On 7/15/08 at 12 Noon, Director of Nurses, E3, was shown R1's incomplete physical restraint assessment dated 4/02/08. It was pointed out that the assessments lacked any documentation related to R1's response to the lap tray restraint such as restlessness, destructiveness or the three falls with injury from the wheelchair after R1 removed the wheelchair lap tray on 3/31/08, 4/19/08, and 6/24/08. E3 was asked if there were any incident reports or fall investigations for these three incidents. E3 indicated that there weren't any. E3 stated that E7 and E11 work on the restraint assessments together, the behaviors and incidents should have been included in the assessments and should been investigated and should have been discussed and included in the careplan for R1. E3 stated it has been a repetitive behavior with the lap tray, it has not been taken off as a reduction because R1 is too quick and he needs it for positioning. E3 stated that having staff remove the lap tray for (R1) is an accident waiting to happen.

On 7/16/08 at 9:05 am Registered Nurse (RN), E7 was interviewed about the quarterly restraint assessments that she completed for R1. E7 confirmed that she had completed the 4/02/08 quarterly assessment for the side rails and the wheelchair lap tray that R1 utilizes. E7 stated that she has been doing the physical restraint assessments for approximately 6 months. She was given the restraint assessment forms and MDS Coordinator, E11 briefly talked to her about the differences between devices used as restraints and those used for safety purposes. E7 stated she does not personally do the

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initial side rail assessments but if the siderails are in place when she does the quarterly restraint review she documents it on the assessment and if there is a change or a need for something different she fills it out on the form. If there is a change or a need for something different E7 fills out a form. E7 stated that all the assessments are kept in the restraint book and E7 gives the restraint assessments she completes to E11 to review. E7 stated that in preparation for the quarterly restraint review, she asks staff that day if there are any concerns or anything new with the restraint use for that resident. E7 stated if the resident is cognitive she will talk to them about any concerns. E7 does not review the nurse's notes for the quarter and does not check for incident reports involving restraints for the resident. E7 said sometimes the staff comes to her to bring her issues with concerns about restraints. E7 stated she was not aware of R1's behaviors of throwing legs over the rails or that he had fallen out of bed after taking the rail off the bed (5/09/08).

E7 stated she was aware that he had fallen after he had broken the lap tray off the wheelchair.(4/19/08).

E7 didn't recall if she did a reassessment of the lap tray after the fall. On 7/16/08 at 10:30 am E7 stated that she checked the restraint book and could not find any additional restraint assessments for R1's use of the lap tray.

The last assessment was 4/02/08. E7 stated that she discussed with the DON, E3 this morning (7/16/08) that she needs more material and training for doing the restraint assessments. E7 stated that "We are doing one to one supervision of (R1) until therapy deems that he is safe to be by himself in the wheelchair."

Therapy Coordinator, E33 stated on 7/10/08, 11:00 am that their therapy group has been working in the facility since June 2008, and the therapy staff is there 5 days per week. E33 stated that they have not been asked by the facility to participate in any restraint assessments yet.

On 7/16/08, Therapy director, E33 stated that the facility had not informed her of any wheelchair seating issues, falls,or restraint issues for R1 until last night (7/15/08). E33 stated she assessed R1 on 7/15/08, due to fidgeting, decreased cognitive and safety awareness, and destructive behavior. E33 stated they have gotten R1 footrests for the wheelchair with a calf (cushion) and they are going to try a graded pommel cushion and front antitipping devices for the wheelchair. E33 stated for right now R1 is using his own lap tray with one to one supervision so he can't get the tray off until anti tipper devices and a pommel cushion with seatbelt can be tried.

C. Based on record review, interview, and observation, the facility failed to accurately assess bed mobility and side rails for (R2). This resulted in R2 being found with her head wedged/entrapped in the vertical bars of the side rail.

CONT.

The facility failed to identify a medical symptom, assess or care plan for the use of hand mitts (R2).

Findings include:

1. R2's Physician's Order Sheet (POS), dated July 2008, list diagnoses which include Dementia, Alzheimer's, Anxiety, Peripheral Vascular Disease and Osteoarthritis. R2's Care Plan, dated 12-31-07 through 06-11-08, shows that R2 required extensive assist with bathing, dressing, toileting, transfers, bed mobility and uses half side rails on her bed.

Nurses Notes, dated 03-14-08, and written by E30, LPN, state, "4:45 a.m., during get up (rounds), staff found (R2's) head wedged between bed rails. Got her out (with) some difficulty. Will request padded bed rails for safety. No apparent injuries noted (at) present." No further entries were seen in the Nurses Notes regarding this incident. R2's Care Plan does not address this safety issue.

During interview with E3, Director of Nursing (DON), on 07-10-08, at 1:00p.m., she stated, "There was no incident report completed." Six months of incident and accident reports were reviewed and there was no report regarding R2's entrapment incident.

A physical restraint informed consent document, dated 04-01-08, shows that R2 was to use full side rails in bed for bed mobility. The quarterly restraint assessment/effectiveness report form, dated 04-24-08, shows that R2 was using full side rails in bed for increased bed mobility and positioning. One of the questions on the report form states, "Have any complications related to physical restraint use been noted"? The response was marked, "No." The assessment did not document the use of wedges being used on the inside of the side rails as a safety measure. There was no mention of R2 being found with her head wedged between the bed rails on 03-14-08. This assessment was completed by E7, Registered Nurse (RN).

An undated document, entitled "INCIDENT REPORTS" states, "Incident shall be defined as an occurrence of an action or situation that is a separate unit of experience, occurring accidentally or by chance. In the event of such a matter, a report shall be filed immediately after the occurrence. The report shall be filed even though no apparent injury is noted; shall be filed on any event that has caused or may cause harm to the person involved. All incidents shall require a minimum of twenty-four hour follow up. Head injuries will automatically be followed up for at least seventy-two hours."

On 07-08-08, at 1:17p.m., R2 was observed lying in bed with 4 half side rails in the up position. Blue wedges were placed on the inner aspect of both top half rails covering the space. Each half rail had 4 vertical posts positioned within the 2 end posts. There was a 7" to 8" space between the 2 long middle vertical posts and an 8" space at each end of the

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side rail and the 2 short inner vertical posts.

On 07-10-08, at 4:35p.m., E15, LPN, stated, "My understanding is (R2's head) was between the actual rails." At this time, she demonstrated with her hands,(palms facing each other), an up and down motion to indicate the vertical rails.

On 07-15-08, at 3:34p.m., E3, DON, stated, "Wedges were placed on side rails immediately." (After the incident.) R2's Care plan, dated 06-11-08, states, "(12-31-07) Side rails (times) 2 when in bed. Provide extensive assist and half side rails." No approaches were found addressing the use of wedges or padded side rails in the 06-11-08 Care plan.

On 07-15-08, at 3:40p.m., E10, Maintenance stated, "I don't recall changing (R2's) side rails. If they were changed I would have gotten a work slip. I may have changed them and forgot about it."

2. R2's history and physical consultation, dated 03-15-08, lists her diagnoses to include Venous Stasis of lower extremity, Peripheral Vascular/Arterial Disease, Osteomyelitis of the left fibula and a nonhealing ulcer of the left leg.

R2's RAI, dated 06-02-08, she requires extensive assist for bed mobility, is totally dependent on staff for care, is incontinent of bowel / bladder, uses no other restraints/devices, and is not on an intervention program for behavior.

During tour, with E3, DON, on 07-08-08, at 9:50a.m., R2 was observed in her bed wearing bilateral hand mitts. At that time, E3, DON, stated, "(R2) scratches face, body, and digs in her stool."

On 07-15-08, at 9:13a.m., R2 was in bed on her right side wearing her mitts.

On 07-17-08, at 9:11a.m., R2 was in bed on her left side wearing a mitt on her right hand, only.

R2's Care Plan dated 07-09-08, lists "mitts on hands (when necessary)" as an intervention for smearing self with (feces).

Physician's Order Sheet (POS), dated July 2008, had no order for mitts prior to 07-08-08. A telephone order dated 07-08-08, reads, "Hand mitts while in bed."

R2's Physical Restraint Informed Consent form, dated 04-01-08, shows "Full rail in bed. Reason-bed mobility." R2's Quarterly Restraint Assessment/Effectiveness Report dated 04-24-08, reflects only the full rails in bed.

There was no evidence of any assessment conducted to assess R2’s need for

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bilateral/unilateral hand mitts.

D. Based on observation, interview and record review the facility failed identify the potential hazard of siderails being used as a physical restraint for 1of 6 sampled residents at risk for falls (R17). The facility failed to identify a medical symptom, assess or care plan for the use of the siderails (R17).

Findings include:

The Physician Order Sheet (POS) dated 7/1-7/31/08 states that R17 had diagnoses of Dementia with Aggression, Paranoid Psychosis, Chronic Thrombocytopenia and Cerebral Vascular Accident. The MDS (Minimum Data Set) dated 5/12/08 states that R17 has cognitive/decision making problems, behaviors and requires extensive assist with transfers, ambulation, dressing, hygiene, bed mobility and toilet use.

The fall assessment dated 5/12/08 identifies R17 as high risk for falls. There is no physical restraint assessment for R17. The undated siderail assessment states, "Does not use" written in the section asking if the siderail is a restraint. E11, Care Plan Coordinator was interviewed on 7/11/08 at 1:00pm. When asked why the siderail assessment for R17 was not done, E11 stated, "The siderail assessment was not done because [R17's] not to be using siderails."

The care plan dated 11/27/07 identifies R17 as having a "potential for falls" with the following interventions identified: "Keep environment free of clutter/obstruction"; "Keep frequently used items within resident's reach"; "Encourage resident to ask for assistance when needed qd[every day]"; "Monitor condition of shoes...."; "Keep call light within reach at all times when in room"; "Therapy to eval [evaluate] and treat per orders"; "Fall risk assessment quarterly and prn [as needed]" and "Assess for need of restorative nursing to increase independence in mobility." The care plan dated 5/13/08 has approaches for a personal alarm dated 6/20/08 and a low bed dated 5/20/08. The care plan does not address the use of siderails. There are no other changes in interventions documented in the Care Plan even though R17 had 14 falls between 3/25-6/16/08.

The Physician Order Sheet dated for June/July 2008 does not have an order for siderails to be used for R17.

The Nurses Notes dated 4/17/08 at 11pm-7am state, "[R17] very upset because previous shift put side rail up. [R17] venting to this writer 'I'm not a 3 [year] old. I don't need rails...."

The Nurses Notes dated 4/18/08 at 7am-3pm state, "SR [siderail up] for [R17's] safety."

The Incident Report dated 4/22/08 at 9:45pm states, "[R17] had gotten up, apparently to

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go to the BR [bathroom]....Made comfortable in bed [with] siderail up, a [personal alarm] on for safety."

The Incident Report dated 4/26/08 at 9:40pm states, "[R17] was just put to bed, [personal alarm] on, [R17] was attempting to go to BR...apparently landed on both knees...put back to bed with siderail up [and] [personal alarm] on."

The Nurses Notes dated 4/28/08 at 3pm-7am state, "[R17] taken to bed SR [up] x 2[times 2]."

The Incident Report dated 5/17/08 at 3:10pm states, "[R17] took [personal alarm] off and climbed over [side] rail, slipped in urine and sat on floor." The section titled Follow Up is blank.

The Incident Report dated 5/20/08 at 4:40am states, "[R17] was found lying on floor.... [R17] had taken [personal alarm] off and climbed out of bottom of bed. Small area to back of head bleeding." The section titled Follow Up is blank. The Nurse's Notes dated 5/20/08 at 7am-3pm stated R17 was placed on a low bed to help prevent future falls.

E3, DON, was interviewed on 7/11/08 at 10:50am. Confirmed there was no investigation of the falls.

E. The facility failed to ensure that the universal style half side rails were maintained in good repair and failed to ensure that the siderails and resident beds were regularly inspected for safety and function. Examples are for R26, R35 and R45.

Findings include:

On 7/16/08 at 12:10 pm Owner, E1 stated that he had personally checked all the resident beds with full side rails to make sure that the rails locks were "clicked in" securely and in place so the rails could not come off. E1 stated that all the resident side rail assessments have been done to ensure that siderail in use were appropriate. **E1** stated that Assistant Director of Nurse's (ADON) E23 , DON, E3 and Restorative CNA, E13 completed the assessments. The facility provided a list dated 7/16/08 of those residents they assessed as needing pads to protect residents from entrapment hazards from the siderails. Those residents included R42, R13, R23, R11 and R43. The list did not include R35, or R2, the resident who had a head entrapment in a siderail in March 2008.

The facility's Roster Matrix dated July 8, 2008 identified ten residents with siderails identified under Restraints, including seven who by observation utilize the older half bedrail with wide opening including R35, R25, R44, R13, R43, R30 and R46.

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Per observations and interview with Maintenance Director, E10 on 7/11/08 at 1:10 pm and random observations throughout the survey, the facility beds in the resident rooms each had four vertical metal posts that are mounted on the framed corner of the bed that are used for securing full side rails on the beds. Each vertical post should be provided with a plastic locking tab at the end of the pole. On 7/16/08 at 8:30 am the unoccupied resident bed by the window in R44's room had two siderail locking tabs on the corner posts that were missing or broken, although the full side rails were not on the bed.

On 7/16/08 at 9:30 am R1's room had a low bed with mats for R1; however the other unoccupied bed in the same room was noted to have a full side rail on one side and no side rail on the other side. Two of the four locking tabs for the vertical side rail posts on each corner of the bed were broken. The tab on the left head of the bed rail post was broken. This allowed the full side rail to pull completely off at the head of the bed. The locking tab on the right foot of the bed was also broken.

On 7/16/08 at 12:30 pm the facility Owner, E1 was shown the broken side rail locking tabs present on the unoccupied bed in R1's room and R44's room with a demonstration of how the full rail was able to be easily pulled off when the locking tab was broken. E1 stated that he would have someone check all the unoccupied beds to remove all the bedrail posts for beds that are not currently in use.

On 7/16/08 at 8:30 am a walk through was made of the facility to view any residents at risk who were still utilizing the unpadded half rails with the wide spaces between the rungs. It was observed that R44's bed which had full length padded rails on tour on 7/08/08, now had unpadded half rails with wide openings.

R26
On 7/08/08 at 2:15 pm R26 was laying in the bed with the head of the bed elevated. The bed was equipped with two metal half side rails. The side rails were an older style that clamped onto the metal bedframe with a tightening screw handle. It was noted that the side rail on the side of the bed was slightly loose on the right side. It could be pulled back and forth approximately 4 inches. R26 stated that she does not use the siderail much. On 7/09/08 at 10:30 am the rail was checked with Maintenance Director E10 who tightened the clamp of the rail to secure it. The spaces between the four vertical rails measured from 8 inches between the middle two rungs to 6 inches between the rungs on either side.

R35
On 7/09/08 at 11:00 am R35 was in a bed that was equipped with four half metal side rails. The head of the bed was elevated and R35 was lying on her back in bed. R35 had contractures of both arms and had hand rolls in each hand. R35 also had a gastrostomy tube feeding running. The upper half side rail that was closest to the door was noted to be bent at a downward angle very loosely attached. It could be moved both side to side

CONT.

and up and down at least 4 inches. There were also openings between the center vertical rails that were approximately eight inches wide at the tapered ends and between the two vertical middle rungs of each side rail. There was also a space where the two half rails on each side of the bed meet. The DON, E3 was in the corridor and was shown the poorly secured rail and the spaces between the four bedrails. E3 attempted to tighten the bracket for the loose side rail and stated that she would have Maintenance Director, E10 check the rails. R35's nurse's notes from 11/16/07- 7/01/08 contain no documented incidents of any falls from bed or any injuries involving the side rails or other equipment.

On 7/10/08 at 8:45 am the bedrails for R35 were reinspected. The inside top rail was still slightly loose; E10 tightened the clamp with the turning knob. E10 stated that these bed rails have a Universal Clamp that attaches to the metal bedframes. E10 stated that he gets a work request if the side rails are loose or need adjusted or changed out. E10 stated he does not have a preventive maintenance plan in place to check of all the side rails for function and safety.

On 7/16/08 at 12:05 pm the lower two half rails had been removed from R35's bed. The remaining two half rails in place at the head of the bed were not padded to prevent entrapment for R35. DON, E3 stated on 7/16/08 at 12:05 pm that they had removed two of the half rails from R35's bed. It was brought to E3's attention that the remaining two rails on her bed are not padded to prevent entrapment. E3 stated she had misunderstood, she was thinking about the spaces that were present between the two half rails on each side of the bed, but not the spaces present between the rails of the individual half rails.

R45

On 7/16/08 at 11:00 am R45 was observed asleep in bed with unpadded half bed rails and a personal body alarm in place. There was a different style of half rail on each side of the bed. Both styles had 8 inch openings between the center vertical rungs. When R45 had been observed on previous occasions including on 7/15/08 at at 4:45 pm, in the wheelchair with a lap tray restraint, R45 had been very restless and was pulling on the lap tray restraint. R45 propels self with feet and was very restless and fidgeting. R45's cognitive impairment and purposeful movements put R45 at risk of entrapment from the unpadded side rails. On 7/16/08 at 12:30 pm R45's new side rail assessment dated 7/15/08 was reviewed. It stated R45 used the half rails for bed mobility.

On 7/16/08 the facility was informed that there were still cognitively impaired residents such as R45 with purposeful movements utilizing the half rails without the benefits of padding or other means to eliminate the spaces between the rails.

Facility Policies:

The facility policy entitled Accident/Incident Protocol documents; "Staff shall recognize those residents who may be more susceptible to accidents/incidents. Preexisting conditions may include; ...decreased vision, decreased hearing, gait deficits, confused

GILMAN HEALTHCARE CENTER — Facility Name
0049981 — I.D. Number

CONT.

metal status, mental retardation, mental illness, seizure disorder, paralysis, agitated behaviors and weakened or debilitated state. Preventative measures shall be taken and followed through on a routine basis as part of our daily care regime....SHOULD ACCIDENT/INCIDENTS TAKE PLACE DESPITE PREVENTATIVE MEASURES AN INCIDENT REPORT WILL BE FILED IN ACCORDANCE WITH FACILITY POLICY."

The facility policy entitled "INCIDENT REPORTS" defines an incident as "an occurrence of an action or situation that is a separate unit of experience, occurring accidentally or by chance. In the event of such matter a report shall be filed immediately after the occurrence. The report shall be filed even though no apparent injury is noted; shall be filed on any event that has caused or may cause harm to the person involved. Examples of such would be falls, bumps, medication errors, drug reactions or in any situation which has involved emergency services. All incidents, despite nature shall require a minimum of twenty four hour follow up." The policy outlined items that must be included in the report including "shall include action taken." The policy does not address conducting a fall assessment or fall investigation to determine the root cause of the incident to identify preventative action or approaches to prevent future occurrences.

(A)

GILMAN HEALTHCARE CENTER	0049981
Facility Name	I.D. Number
1390 SOUTH CRESCENT STREET, GILMAN, ILLINOIS 60938	
Address, City, State, Zip	
02630	AUGUST 7, 2008
Reviewed By	Date of Survey
ANNUAL LICENSURE	02462, 02522, 26409, 13108, 15407, 02616, 02544, 25071
Type of Survey	Surveyed By

As a result of a survey conducted by representative(s) of the department, it has been determined the following violations occurred.

IMPORTANT NOTICE: THE STATE AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED UNDER PUBLIC ACT 83-1530. DISCLOSURE OF THIS INFORMATION IS MANDATORY. THE FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

"A" VIOLATION(S):

300.610 a)
300.1210 a)
300.3240 a)
300.3240 b)
300.3240 c)
300.3240 f)

Section 300.610 Resident Care Policies

a) The facility shall have written policies and procedures, governing all services provided by 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

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 psychosocial well-being of the resident, in accordance with 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.

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)

CONT.

d) A facility administrator, employee, or agent who becomes aware of abuse or neglect of a resident shall also report the matter to the Department. (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)

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 there residents and employees of the facility. (Section 3-612 of the Act)

These requirements are not met as evidenced by:

A. Based on interview, observation, and record review the facility failed to:
   (1) Recognize an abusive situation involving a staff member and R14 (1 of 15 sampled residents). Administration failed to immediately initiate an investigation after receiving an allegation of staff withholding medication from R14 and refusing to allow other staff to administer R14's medication.
   (2) Follow the policy for medication administration for R14 (1 of 15 sampled residents). Staff failed to document the reason for medication refusal and did not notify the Physician of repeated refusal. Staff repetitively withheld medication and refused to allow other staff to administer medication to R14.
   (3) The intentional repetitive withholding of medication and subsequent threat of discharge as punishment resulted in mental abuse to R14. Staff did not identify withholding of medications as abuse, did not remove the alleged perpetrator, and did not conduct an investigation and report to the Illinois Department of Public Health.

B. Based on record review and interview, the facility failed to:
   (1) Report and investigate allegations of mental, verbal and physical abuse involving employees and R14, R17, R22 (3 of 15 sampled residents).
   (2) Protect residents from further abuse by allowing the alleged perpetrators (employees) to continue working in direct resident contact.
   (3) Initiate an investigation after receiving an allegation of a staff member withholding medications from R14, allowing the abuse to continue.

GILMAN HEALTHCARE CENTER — 0049981
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CONT.

(4) Implement the policy for Resident to Resident Altercations for R17 (1 of 2 sampled residents with physically aggressive behaviors).
(5) Investigate repeated resident to resident altercations (R17, R1, and R29).
(6) Assess, develop and implement a behavior management program to prevent further resident to resident altercations
(7) Protect R1 and R29 from R17 by implementing appropriate and adequate interventions.

C. Based on interview and record review, the facility failed to operationalize their abuse policies and procedures relating to Mental, Physical and Verbal Abuse, Neglect and Resident to Resident Altercations and failed to ensure that staff was knowledgeable on how to initiate and implement the Abuse Policies and Procedures.

EMPLOYEE TO RESIDENT ABUSE

Findings include:

[R14]:

1. R14's Physician's Order Sheet (POS), for July 2008, shows diagnoses which include Cerebral Palsy, Aphasia, and Betagalactosidase Deficiency.

R14's Psychiatric Evaluation by Z6, Psychiatrist, dated 06-03-05, shows mental health diagnosis that includes Oppositional Defiant Disorder.

R14's Psychological Evaluation, dated 08-08-00 and 08-03-00, states, "(R14) has been diagnosed with Cerebral Palsy and Betaglactosidas Enzyme Deficiency, ...which leads to brain degeneration and progressive neurological dysfunction. This diagnosis suggests continued deterioration of his cognitive and motor skills as his condition degenerates. R14 is functioning in the profound range of mental retardation due to his physical disabilities. (R14's) most recent ICAP (Inventory for Client and Agency Planning), dated 08-10-00, states, "(R14's) service score...places him at a level requiring the need for extensive personal care and/or constant supervision. This significant decline in adaptive functioning is likely caused by the degenerative nature of his disease."

The July 2008 POS contains orders for Ascorbic Acid 500 milligrams (mgs) daily, Claritin 10 mgs, daily, Omeprazole 20 mgs daily, one-tab-daily with iron tablet daily, Valium 2 mgs at 8:00 a.m. and 12:00 p.m., Valium 7 mgs at 8:00 p.m., Senna-gen tablet 2 tablets daily, Baclofen 10 mgs twice a day, Nabumetone 500 mgs twice a day and Ultram 50 mgs every 6 hours.

R14's Social History upon admission, dated 10-22-01, states, "(R14) is his own (Power of Attorney) and wants to continue to speak for himself." On 07-10-08, at 10:00a.m., R14's parents confirmed that he makes his own decisions and won't give that up.

CONT.

R14's Resident Assessment Instruments (RAI), dated 09-17-07 and 05-26-08 show that R14 extensively depends on staff for transfers, ambulation, dressing, eating, bathing, and toileting. The RAI shows that R14 has limited range of motion in his neck, legs, arms, hands and feet. Observation during the initial tour (07-08-08), at 9:30a.m., and throughout the survey (07-08-08, 07-09-08, 07-10-08 07-11-08), showed contractures of R14's hands, arms, legs and feet. R14 was observed during the survey to use his left index finger to communicate by typing words on a computerized keyboard that verbalizes what he has typed.

R14's screening assessment "to determine the presentation of Abuse and/or Neglect", dated 03-05-08, indicates that R14 is at high risk for becoming a recipient of abuse. And, it states that this assessment is a "risk measure for likelihood of previous/recent mistreatment and potential future problems/symptoms related to mistreatment."

R14's Care Plans dated 03-05-08 and 06-04-08, fail to address his risk for becoming a recipient of abuse.

On 07-08-08, at 9:43a.m., R14 communicated to surveyor that he had some issues with the facility and that he wanted E26, Licensed Practical Nurse (LPN) present when he talked with surveyor.

On 07-08-08, at 1:37p.m., E26 accompanied surveyor to R14's room. R14 communicated that, "Every time (E30, LPN) works, and I am her patient, she throws away my medications without asking me (if I want to take them)." R14 typed, "Angry" on his key board. "(E2, Administrator,) says me and (E30) have to stop or that I was going to be kicked out of facility." During this interview with R14, E26, LPN, stated, "On Saturday/Sunday, I worked with (E30, LPN). (R14) asked me to give him his medications. I asked (E30) if she still had his medications. She told me (R14) wouldn't take the medications, so, she threw them away. I asked (E30) if I could re-pop (R14's) medications and (E30) said, 'NO'. (E1, Owner and E2, Administrator), were in that Sunday and spoke with (R14). (E2) said that (R14) had to take his medications from (E30) if she is his Nurse."

The Nursing schedule for June 2008 showed E26 and E30 worked together on June 15, 2008 during the day shift.

On 07-08-08, at 4:55p.m., E2, Administrator and E3, Director of Nursing, were interviewed regarding R14's accusations. E2 stated, "Yes, we knew what happened. He will get on his high horse and refuse to take his medications from (E30). I'm not going to start that with someone else going down to give him his medications. There is no reason for him to do this. He picks targets. The policy is to go into his room with 2 people. It is on his Care Plan. This has been discussed with his parents. They talk to him and he takes his medications for awhile and then starts again. We have had multiple discussions

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about refusing medications. I have no documentation in here. (E3) would have. She is the Abuse Coordinator. If you give in to (R14), he finds someone else to target."

During interview on 07-08-08, at 5:07p.m., with E3, Director of Nursing, E3 stated, "I have no documentation of discussions with (R14) or his parents. (E2, Administrator) could probably tell you. (The incident) happened a day in June, second or third week. (E30) documented the issue. (E26) told me it happened while I was on vacation. (R14) has a vendetta against (E30). It has been some time since (R14) has seen the Psychiatrist, (Z6)."

Review of R14's Nurse's Notes, written by E30, LPN, contains the following documentation:

"04-10-08, 4:00p.m., Asked (R14) if he wanted his pills ...'F...you, you b....' (expletives). I left his doorway."

04-17-08, 3:00p.m.-11:00p.m.,"Refusing (medications). No other behaviors."

04-23-08, 3:00p.m.-11:00p.m.," (No) unusual behaviors. Refusing (medications) as usual."

04-25-08, 3:00p.m.-7:00a.m.," (refused medications)."

04-26-08, 4:00p.m.," I called (E2, Administrator) (informing) her (of) (R14's) refusal to take pills. She advised me to go and tell him she said he should take his pills. I told her I would and (R14) also wanted his folks called, which I told her and also (R14) I'd call them. I went back into (R14's) room, told (R14) I spoke to (E2, Administrator) and she said I needed to tell him to take the pills. Also, I'd call his folks. (R14) said, 'you're a dirty filthy pig and worse than the devil.' I called and spoke to (Z4), (R14's) Mother. We discussed in length this situation. His parents will be out here either today or tomorrow to talk with him. I said it isn't necessary; (R14) is (R14). He's got a right to refuse his pills, but, as long as I'm his (Nurse), if he won't take them from me, no other (Nurse) is going to give them. I've done nothing to him."

04-28-08, 3:00p.m.,-11:00p.m., " (No) (medications) taken."

06-15-08, 7:00a.m.,-3:00p.m., "Still refusing (medications)."

R14's Care Plans dated 03-05-08 and 06-04-08, fail to address his refusal to take his medications from E30.

On 07-11-08, at 3:50p.m., when E11, Care Plan Coordinator (CPC) was questioned as to why R14's refusal of medications was not included in his Care Plans for 03-05-08 and

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06-04-08, she stated, "I never heard that (R14) was refusing his medications." When asked if she had spoken to him prior to his Care Plan, she stated, "The one and only time I went to talk to (R14), he told me to 'f... off.' (expletive) That was in September 2007."

During telephone interview, on 07-09-08, at 2:29p.m., with E30, LPN, she stated, "(R14's) a trouble maker. I will not let another Nurse give him his (medications) if I'm his Nurse. It's like giving in to a child with temper tantrums. He is refusing the (medications). It's his problem, not mine. I say, (R14) do you want your (medications)? If he says 'No', I waste them. Now that I know that he won't take them from me, I don't prepare them. I ask him if he wants to take them first. He told people a while back that I was getting Social Security and working, also. (R14) didn't think that was right."

On 07-19-08, at 2:15p.m., E30 came to the facility requesting to speak with a surveyor about R14. E30 began saying that she had done nothing wrong. That R14 was abusing her rights by getting her fired. She again stated, "(R14's) like a child having a temper tantrum." At 2:20p.m., E3, DON asked E30 to leave the building and escorted E30 down the hall toward the exit door.

During family interview, with Z3 and Z4, on 07-10-08, at 10:00a.m., they stated, "(E30) called one day and told us she was fed up with (R14's) refusal to take his (medications). (R14) was seen by a geneticist in 1982 and diagnosed with the degenerative disease. Enzymes are not used by his body. He has lost control of almost everything. There are limited things he has control of with his condition."

R14's Social Service Notes for June 2008, shows E24, Social Service Designee (SSD), has documented numerous times that "There is a Nurse that (R14) doesn't like and will refuse his medications... when she is here." There is no documentation that E24 attempted to or discovered why R14 refuses his medications from E30.

During interview with E6, LPN, on 07-15-08, at 9:19a.m., she stated, "(R14) takes (medications) from me without a problem. If I'm here I give him his medications because I know he won't take them from (E30). He hasn't liked her since she started here."

On 07-09-08, at 2:10p.m., E32, Certified Nurse Aide (CNA) stated, "(R14) said, when me and (E35, CNA) showered him (this morning), that (E2, Administrator), told him 'one more time and he would be out of here.' I reported this today to (E3), Abuse Coordinator because I wanted her to know what he said."

On 07-09-08, at 4:00p.m., E3, Director of Nursing and Abuse Coordinator, stated, " I talked to (E2, Administrator), about what (R14) had alleged to (E32), about kicking him out of the facility. (E2) denied it, so, I didn't go any further with it." When asked if the allegation was reported to the Illinois Department of Public Health, E3 stated, "No."

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On 07-09-08, at 6:15p.m., it was explained to E3, Abuse Coordinator, that according to the Abuse policy, she should have suspended E2, Administrator, pending an investigation after receiving the allegation. E3, Abuse Coordinator stated, "That put me in a very uncomfortable position. (E2) and I have worked together for over 20 years." E3 had no documentation of the investigation regarding the abuse allegation involving R14. Nor were the allegations reported to the Illinois Department of Public Health.

On 07-09-08, at 2:20p.m., E27, CNA stated, “(R14's) refusal of medications has been due to a family thing about (E30) and (Z3). (R14) won't take medications from (E30)."

Review of R14's Medication Administration Records (MAR) for April, May and June 2008, shows E30's initials circled for 23 days/ 64 doses of medications that E30 indicated R14 refused. There is no documentation of reason for the refusal or that an alternative approach/intervention was implemented to encourage R14 to take his medications. On 07-09-08, at 5:20p.m., E3, DON, identified/ confirmed E30’s initials on these MARs for April, May, and June 2008.

The facility's (LONG TERM CARE) (MEDICATION) PASS GUIDELINES, undated, state, "RESIDENT RIGHTS/DIGNITY: Residents have the right to refuse medications." A list of situations as to when to notify the Physician includes "consistent refusal of medications." 2 of 13 items regarding medication errors are defined as "not in accordance with professional standards, and medication omitted."

R14's records fail to show that any education regarding his refusal of medications was given to him and that he was informed of the consequences of not receiving his medications.

The facility's ABUSE PREVENTION PROGRAM POLICY dated September 2004 states, "Abuse.... also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain and /or maintain physical, mental, and psychosocial well being. This assumes that all instances of abuse of residents cause physical harm, pain or mental anguish."

The facility's ABUSE PREVENTION PROGRAM POLICY dated September 2004, defines Neglect as "the failure to provide goods and services necessary to avoid...mental anguish, mental illness, or in the deterioration of a resident's physical or mental condition."

The facility ABUSE PREVENTION PROGRAM POLICY, dated September 2004, states, "The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of mistreatment, neglect or abuse of our residents. Employees are required to report any occurrences of potential mistreatment they observe, hear, or suspect to a supervisor or the administrator. Such reports...will be thoroughly

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investigated. Supervisors shall inform the administrator or designee of all reports of potential mistreatment. Upon learning of the report, the administrator/designee shall initiate an incident investigation. Employees ...who have been accused of mistreatment will be removed from resident contact immediately until the administrator /designee has reviewed the results of the investigation. Employees accused of possible mistreatment shall not complete the shift as a direct care provider to residents. The investigation will be conducted following the investigation procedures of this policy. Within 24 hours after the knowledge of the occurrence, a written report shall be sent to the Department of Public Health."

According to the June and July 2008 nursing schedules, E30, LPN and alleged perpetrator continued to work in direct contact with residents until July 9, 2008 when she was suspended pending investigation into alleged abuse. E2, Administrator and alleged perpetrator, continued to work until July 9, 2008 when she was suspended pending an investigation into alleged abuse.

On 07-08-08, at 10:00a.m., during the Entrance Conference meeting with E2, she stated, "I don't have any abuse allegation investigations."

On 07-08-08, at 5:00p.m., when E2, Administrator was asked a second time, for the investigations conducted for allegations of abuse, she stated, "(R15) was the only investigation done since last annual survey."

During interview with E23, LPN, Assistant Director of Nursing, on 07-16-08, at 4:00p.m., she stated, "(R14) didn't like (E30, LPN), but I didn't know he was refusing medications (from her).

According to the facility's ABUSE PREVENTION PROGRAM, dated 09/04, when there is an allegation of abuse involving an employee, "who has been accused of mistreatment will be removed from resident contact immediately until the administrator or designee has reviewed the results of the investigation. Employees accused of possible mistreatment shall not complete the shift as a direct care provider to residents.

Employees are required to report any occurrences of potential mistreatment they observe, hear about, or suspect to a supervisor or the administrator. Supervisors shall inform the administrator or designee of all reports of potential mistreatment. Upon learning of the report, the administrator or designee shall initiate an incident investigation.

Individualized care plans are developed that recognizes individual rights and addresses the individual need for safety, security and restoration of function. Within 24 hours after the knowledge of the occurrence, a written report shall be sent to the Department of Public Health."

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On 07-11-08, at 3:15p.m., when questioned about her knowledge of the Abuse policy, E24, Social Service Designee (SSD), stated, "There has not been an Abuse inservice in the last year. I would confront the staff. No inservice from (E1, Owner/Operations manager)." E24 appeared confused, nervous and didn't know quite what to say. When asked what happens to the alleged perpetrator of Abuse, E24 gave an incorrect response. On 07-11-08, at 3:45p.m., E24 came to surveyor and said, "I just did have an (Abuse) inservice with (E1). I just forgot."

The facility's ABUSE PREVENTION PROGRAM, dated 09-04, and defines Verbal abuse as "the use of oral, written or gestured language that includes disparaging and derogatory terms to residents within their hearing or seeing distance."

[R22]:
2. During review of E28's, Certified Nurse Aide (CNA) personnel file, on 07-11-08, the following memo undated, and without an addressee, was discovered: "I feel that it would be a good idea for (E28, CNA) not to take care of (R22). It seems that the two of them can not get along. (R22) frequently picks at and insults (E28). In turn, (E28) tends to pick back and at times has spoken inappropriately to (R22). In one instance (E28) stated to (R22), 'I am not going to argue with your ass.' This was heard by me. (E28) was told that it was inappropriate and that she could not speak to the residents that way. I am ...very aware of how stressful the relationship between (R22) and (E28) is. I have tried several times to explain to (E28) how her approach to (R22) can make dealing with her much easier." This document was signed by E36, Registered Nurse (RN).

On 07-11-08, at 12:07p.m., E3, Abuse Coordinator, stated, "I wasn't aware of this (memo regarding R22). There would have been a big investigation. (E28) was terminated on 04-14-08. She was a 'no call/ no show.' I should have documented something (in her personnel file), but I didn't."

E28's Time Clock Report confirms that E28 was a full time employee until 04-14-08.

On 07-14-08, at 8:21a.m., E36, RN stated, "I can't remember the date the memo was written. The memo was given to (E2, Administrator). I wrote the memo the night of the episode and slipped it under (E2's) door. I told (E28) not to go into (R22's) room anymore. (E2) did not question me about memo. I think (E3, Abuse Coordinator), talked to (E28). If it had been physical abuse, I would have sent (E28) home immediately and called (E3 and E2)." When asked about the last abuse inservice E36 had attended, she stated, "This facility has inservices at 2:00p.m. and, I am working at that time at (another facility). They put the inservice on the bulletin board and I read it when I come to work."

On 07-08-08, at 10:00a.m., and at 5:00p.m., E2, Administrator was asked for any investigations on allegations of abuse. At 10:00a.m., she said she had no investigations.

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At 5:00p.m., she stated she had only 1, R15's, since the last annual survey.

On 07-16-08, at 4:00p.m., E23, LPN, and Assistant Director of Nursing, stated, "I was not aware of the verbal abuse allegation involving (R22 and E28).

Abuse allegations were not reported to the Illinois Department of Public Health. The facility's ABUSE PREVENTION PROGRAM, dated 09-04, defines Physical abuse as "the infliction of injury on a resident that occurs...and that requires medical attention."

[R17]:

3. Nurse's Notes, dated 03-30-08, written by E6, LPN, 7:00a.m. To 3:00p.m. Shift, states, "(R17) upset from the minute shift began. Requesting to file a formal complaint and file charges with the Police. Claims a male CNA 'brutalized him.' Showed Nurse (left) hand where bandaid was present. 'He twisted my wrist.' (R17) attempted to demonstrate and continued to say, 'He put his hands on mine like this when my hands were resting on the wheelchair like this. Then he shoved Me.' ...Began to complain of pain at 10:00a.m. (Pain) medication given. After lunch, (R17) went to bed and napped all (afternoon)."

The Nursing schedule for March 2008 shows that E25, CNA, was the only male staff working 10:30p.m. to 7:00a.m. On 03-29-08. It was the shift prior to 03-30-08, 5:30a.m. To 2:00p.m. When R17 reported his allegation of being brutalized.

E25's Time Clock Report shows that E25 was allowed to continue working in direct contact with residents.

Nurses Notes, dated 03-30-08, written by E15, LPN. 3:00p.m. to 11:00p.m. Shift, states, "4th and 5th fingers on (left) hand noted to be slightly puffy and discolored along with back of hand."

Nurse's Notes, dated 03-31-08, written by E14, LPN, 11:00p.m. to 7:00a.m., shift, states, "(Pain) medication given for (left) hand pain. (Complains of) puffy fingers. Difficult to bend."

Nurse's Notes, dated 03-31-08, written by E15, LPN, 3:00p.m. to 11:00p.m., shift, states, "Medications given for ....pain. (Left) hand remains discolored and tender to touch."

On 07-08-08, at 10:00a.m., during the Entrance Conference meeting with E2, she stated, "I don't have any abuse allegation investigations."

On 07-08-08, at 5:00p.m., when E2, Administrator was asked a second time, for the investigations conducted for allegations of abuse, she stated, "(R15) was the only investigation done since last annual survey." There were no abuse allegations reported,

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no investigations conducted, alleged perpetrators were not removed from direct resident contact, and the Illinois Department of Public Health was not notified of any allegations of abuse.

RESIDENT TO RESIDENT ABUSE
Findings include:

Policies:
The facility neglected to implement the policy titled "Abuse Prevention Program" as it relates to Resident to Resident Altercations. The policy states the following:

"The facility completes a screening assessment to determine abuse or neglect risk on all residents within the first fourteen days of admission and annually, and upon an occurrence of abuse or neglect. This assessment will be used to help identify persons who may present with a greater than normal risk for mistreatment in a residential setting, Appropriate interventions will be developed based upon the degree of risk and need for attention."

"Resident Assessment. Upon admission, as part of the resident social history assessment, staff will identify residents with increased vulnerability that has needs and behaviors that might lead to conflict. Quarterly thereafter, as part of the care planning process, staff will identify any problems, goals and approaches, which would reduce the chances for mistreatment for these residents."

"During orientation and as ongoing training of employees, the facility will cover the following topics: Assessing risk factors for suspected victims of abuse and/or neglect; How to assess, prevent and manage aggressive, violent and/or catastrophic reactions of residents in a way that protects both residents and staff."

"If a resident complains of physical injuries or if resident harm is suspected, the resident physician will be contacted for further instructions."

"Residents who allegedly mistreated another resident will be removed from contact with that resident during the course of the investigation. The accused resident's condition shall be immediately evaluated to determine the most suitable therapy, care approaches, and placement, considering his or her safety, as well as the safety of other residents and employees of the facility. A room change... may be indicated...."

[R17]:
The Physician Order Sheet (POS) dated 7/1-7/31/08 states that R17 had diagnoses of Dementia with Aggression, Paranoid Psychosis, Chronic Thrombocytopenia and Cerebral Vascular Accident. The Admission Face Sheet documents that R17 was admitted to the facility on 11/16/07. The MDS (Minimum Data Set) dated 5/12/08 states that R17 has

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cognitive/decision making problems and behaviors including: persistent anger, repetitive health complaints, repetitive anxious complaints, insomnia, and sad expressions and is verbally abusive, socially inappropriate and resists care.

The facility "Screening Assessment to Determine the Presentation of Abuse and/or Neglect" dated 11/19/07 states that R17 is at "High Risk" for "likelihood of previous/recent mistreatment and potential future problems. Symptoms related to mistreatment." The assessment documents that "yes" was checked for the following screening indicators: "Psychiatric history (mental illness) and/or present mental health diagnosis"; "History or presence of provoking, aggressive, manipulative, derogatory, attention seeking, obnoxious, abhorrent, and /or otherwise abrasive/inappropriate behavior that would increase the likelihood of (R17) becoming a recipient of abuse" and "(R17) admits to a history of mistreating others (...verbal/physical abuse)...."

The hospital History and Physical dated 11/27/07 states R17 was recently admitted to the nursing home about 10 days ago. "[R17] was brought in as he has been becoming increasingly aggressive at ...Nursing Home and recently grabbed a nurse's finger and broke it. He has a history of aggression and has been at other nursing homes in the past. The nurse at this nursing home also reports that [R17] has thrown a desk before. When asked about his behaviors, [R17] justifies them saying they were not treating him right, and they were acting badly towards him, and that is why he had to do these things, and he does not appreciate having many people come upon him at the same time. He shows no remorse for his behavior. He becomes agitated quite easily and has, therefore, been transferred from other nursing homes, also." The History/Physical and Discharge Summary were not in R17's medical record. The records were faxed from the hospital to the nursing home on 7/10/08 at 10:27am.

The Care Plan dated 11/27/07 states, "(R17) displays agitated behavior, dx [diagnosis] of paranoia" and The Care Plan dated 11/27/07 does not identify R17's history of physical/verbal aggression at other nursing homes prior to admission. The Care Plan does not identify that R17 broke a nurse's finger, does not want a roommate, gets agitated when writing checks to pay for his stay, etc. The approaches are not specific to the situations which agitate R17.

[R17-R1]:
The Nurses Note dated 3/20/08 at 3-11pm states, "(R17) very upset over assignment of new roommate.... (R17) did not want that kind of person (R1) in his room."

The Nurses Notes dated 3/21/08 to 4/17/08 document R17 being agitated, upset over having a roommate (R1) and threatening R1 numerous times. R17 threatened to "push (R1) over" or "throw (R1) out."

E25, CNA (Certified Nurse Aide), was interviewed on 7/24/08 at 2:05pm. E25 stated he

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was going down the hall on 3/30/08 and saw R17 standing over R1. E25 stated R17 was not doing anything to R1 but he reported it to the nurse. E25 stated R17 was "always agitated because he had a roommate, so we would watch (R17) because you never knew what (R17) was going to do."

E23, Assistant Director of Nursing (ADON), was interviewed on 7/24/08 at 11:30am. When asked if she had notified Z6, Psychiatrist, of R17's aggressive behaviors toward his roommate and staff, E23 stated she may have called Z6. At 11:50am E23 confirmed there was no documentation of notifying Z6 of R17's behavior but thought she might have called Z6's office as R17 had an appointment for 4/3/08. E23 stated medication changes for R17 would also indicate that Z6 had been notified.

The POS has a Physician's Order dated 3/21/08 for R17 "To see [Z6] 4/3/08 at 2pm." The March, April and May POS's were reviewed. There were medication changes for R17 except on 3/6/08 and 4/3/08 which coincide with R17's visits to Z6's office. There is a Physician's Order dated 4/16/08 to decrease R17's Seroquel to 75mg bid. E3, Director of Nurses (DON) stated in interview on 7/11/08 at 10:50am that she called Z6 about R17's falls and Z6 changed R17's medications.

The Nurses Notes dated 5/26/08 at 3-11pm state, "[R17] became agitated. Refusing medications, wanting police called for our ‘inability to care' for him. 1:1's repeatedly [without] success.... [R17] continued to become more and more aggressive to staff kicking cursing and striking staff. Chasing staff down the hallways in w/c [wheelchair]. Began throwing anything he could get his hands on. Pulled nurse's hair when she attempted to pick up books he threw. [Physician] notified..... While waiting for ambulance to arrive [R17] approached his roommate [R1] began cursing and struck [R1] in the face before staff could intervene. [R17] separated from all peers." R17 was admitted to the hospital Psychiatric Unit.

E7, Registered Nurse, was interviewed on 7/24/08 at 11:40am. When asked about the incident on 5/26/08, E7 stated they tried 1:1s, reality orientation and leaving R17 alone but nothing worked, the behaviors just kept escalating. E7 stated R17 threw books and pulled another nurse's hair. E7 stated she had just got off the phone with the Physician when she heard R17 down the hall yelling at his roommate R1. E7 stated by the time she got down the hall, she saw R17 strike R1 in the face. E7 stated R17 struck R1 with an "open handed smack." When asked how R1 reacted, E7 stated, "[R1] really did not react. I think he was in shock."

E23, ADON, confirmed in interview on 7/24/08 at 1:25pm that when R17 came back from the hospital he went back to his old room with R1. E23 stated she was not aware that R17 actually hit R1; she thought he had only threatened to hit R1.

E3, DON was interviewed on 7/9/08 at approximately 10:00am. When asked about the

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incident with R17 on 5/26/08 E3 stated she just now became aware of it, did not remember the incident. E3 stated she did not receive a phone call or have a message about the incident of 5/26/08. E3 confirmed there was no investigation of the incident.

[R17-R29]:
The Nurses Notes dated 6/13/08 and 6/14/08 document that R17 was upset about moving to another room with a new roommate (R29). The notes document that R17 moved into the room with R29 on 6/14/08.

The Nurses Notes dated 6/16/08 at 7am-11pm state, "...Went to bed [and] cooperated with HS [hour of sleep] care but soon after was found crawling on floor [and] had obtained roommate's [R29] foot pedal, was refusing to give it back to staff, 1:1 coaxing not effective. 2 staff members had to remove it from [R17]."

E25, CNA, was interviewed on 7/18/08 at 2:55pm. When asked about the incident involving R17 and R29's wheelchair leg, E25 stated, "I was going by [R29's] room and [R17] was on the floor crawling on his hands and knees with the wheelchair leg in his hand. [R17] was on the floor at the side of [R29's] bed." When asked if R17 said anything, E25 stated, "[R17] had the wheelchair leg in his hand and said I'm going to kill that...." E25 stated he just happened to see R17 on the floor; R17's personal alarm did not go off because he knew how to remove the alarm.

The Nurses Notes dated 6/17/08 at 11pm-7am for R29 state, "Alert and orientated with periods of confusion and forgetfulness, [R29] worried about roommate [R17] hurting him [after] episode on previous shift. On call light numerous times to make sure he [R17] was still in bed...."

E4, LPN (Licensed Practical Nurse), was interviewed on 6/18/08 at approximately 1:45pm. E4 stated that R29 was anxious that night (6/17) because of what happened with the wheelchair leg on the evening shift. E4 stated, "[R29] wanted us to make sure that (R17) was still in bed. (R29) said, 'He [R17] was going to hurt me, but they [E25] saved me'." E4 stated that R17 "always threatened to hurt his roommate (R1)." When asked what R17 threatened, E4 stated, "I'm [R17] going to take their stuff out; this is my [R17] room, I'm going to beat them up." E4 stated, "This was [R17], he was delusional, he was very territorial."

E3, DON, was interviewed on 7/9/08 at 10:00am. E3 stated she talked to R29 about the incident with the wheelchair leg and R17. E3 was unable to remember what staff she talked to about the incident and has no investigation of the incident documented.

Z1 stated in confidential interview that on approximately 7/1/08 there was a blowup with R29 and his roommate R17. Z1 stated that R17 took a swing at R29. Z1 stated about a month ago R17 "picked up a wheelchair leg and was going after [R29] late at night,

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[R17] crawled across the floor with the leg rest of the wheelchair and a male staff member came in the room." Z1 stated she talked with E2, Administrator, on 7/1/08 about the situation with R29 and R17. Z1 stated she was told by E2 that R17 was going to be moved to another room. Z1 stated when she returned to the facility on 7/6/08, R17 was still residing with R29 in the same room.

R29 was interviewed on 7/9/08 at approximately 11:30am. When asked about the incident with R17 on 7/1/08, R29 stated, "[R17] came out of the bed and started toward me--[R17] took a swing at me. I [R29] drew back with the pencil. I told [E1, Owner] immediately about it. I told [E1] I [R29] was going to bury it [pencil] in his [R17] chest. I was ready in case I had to defend myself."

E1, Owner, was interviewed on 7/9/08 at 3:30pm. E1 stated, "[R29] had a pencil in his hand as self defense if [R17] would hit him. [R29] was bothered [R17] would hit him--would have a way to defend himself." E1 stated he did not remember R29 saying that R17 tried to hit him. E1 stated after talking to R29, he made E3, DON, or E2, Administrator, aware of the situation.

There is no documentation in R17 or R29's record of the incident on 7/1/08.

E24, Social Service Director was interviewed on 7/9/08 at 10:35am. When asked about the incident (7/1), E24 stated, "I think [R17] got mad at [R29]. [R29] and his sister brought it up at the care plan meeting." E24 confirmed the incident occurred on 7/1/08. E24 confirmed that she did not document the incident in the Social Service Notes.

E3, DON, was interviewed on 7/9/08 at approximately 10:00am and 10:50am. E3 stated there was 1 incident with R17 and R29. E3 stated R17 "waved his fist in the air", was angry about another situation. When asked about R17 swinging at R29, E3 stated, "[R29] did not share with me that [R17] almost hit him. E3 confirmed there was no investigation of the incident.

The Care Plan dated 5/13/08 does not identify what situations trigger R17's behaviors such as R17 does not want a roommate, threatens and curses the roommate, gets agitated when writing a check to pay for his stay or when his wallet gets washed with the laundry. The Care Plan does not identify specific approaches for staff to use to calm R17.

E24, Social Service Director, was interviewed on 7/9/08 at 10:35am. When asked what interventions were done for R17's behaviors, E24 stated, "1:1s, talk [to him] to try to calm him. Sometimes it works. E24 stated R17 does not want a roommate and accused one roommate of taking his things. E24 stated after coming back from the 11/27/07 hospitalization R17 was moved to Room... and did okay until he got a roommate (R1). E24 stated, "[R17] did not want a roommate, [R17] did not like [R1]."

CONT.

E6, LPN, was interviewed on 7/8/08 at 10:25am. When asked about R17 and his behaviors E6 stated, "[R17] does not want a roommate, it doesn't matter who it is, he just does not want a roommate." E6 stated that R17 would complain about R1 shaking the rails at night.

The facility failed to implement a behavior program with interventions specific to preventing resident to resident altercations. R17 had repeated resident to resident altercations with R1 and R29.

(A)