STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E163	A. BUILDING ______ B. WING ______	12/03/2008

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SOMERSET PLACE	5009 NORTH SHERIDAN CHICAGO, IL 60640

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F 000	INITIAL COMMENTS Annual Certification Survey Complaint Investigations: 0884471 / IL37634 ==> F159 0884817 / IL38003 ==> F252, F253 FOSS Survey An Extended Survey was conducted.	F 000		
F 154 SS=E	483.10(b)(3), 483.10(d)(2) NOTICE OF RIGHTS AND SERVICES The resident has the right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. The resident has the right to be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well-being. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to assure that 5 of 30 sampled residents (R13, 17, 18, 23 & 25) are not given psychotropic medications without informed consents. Findings include: 1. R23 is an alert and oriented times three female resident who has been receiving	F 154		1/11/09

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 154	Continued From page 1 Risperdal 2 mg every morning and 4 mg at bedtime. During clinical record review, R23 had a psychotropic medication consent in the chart without signature, it was left blank. R23 did not have consent for psychotropic medications administered to her. 2. R25 was admitted into the facility on 10-22-08 with schizoaffective disorder. Chart review showed that R25 has an order for three different kinds of antipsychotic medications namely: Haldol, Lorazepam, and Risperdal. The facility did not have a consent from the resident or a guardian for the use of these drugs. The medication Lorazepam was given four times already, on 10-24, 10-25, and 10-26-08, and no evidence of a consent is present in R25's records. 3. R13 was admitted with a diagnosis including Schizoaffective Disorder, and was on Haldol; Clozapine and Depakene medications. R13's record did not contain any psychotropic consents. E15 (nurse) of R13 was interviewed on 10/28/08, and stated,"R13 psychotropic consents are lost.....we will try to get resident to re-sign." 4. R17's consent for psychotropic medication does not include Haldol Decanoate 150mg., intramuscularly, every two weeks nor the actual dose for Depakote 1500mg. at 9p.m. 5. R18's record did not contain any psychotropic medication consent for Depakote 250mg. at 12p.m., 5p.m. and 500mg. at 9p.m.	F 154		
F 159 SS=D	483.10(c)(2)-(5) PROTECTION OF RESIDENT FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and	F 159		1/11/09

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F 159	Continued From page 2	F 159		

account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section.

The facility must deposit any resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.)

The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund.

The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.

The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.

The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.

The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources,

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reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.

This REQUIREMENT is not met as evidenced by:
Based on interview and record review the facility failed to assure policy is followed for obtaining a resident signature on a check prior to facility depositing the funds for 1 of 30 sampled residents (R18).

Findings Include:

R18 was admitted to the facility on 03/27/08. R18 was interviewed on 10/28/08 and stated that in May 2008 he received a social security check in care of the facility for $3109.74. During interview R18 stated he was told by E1 (Administrator) and an employee for Social Security that he was entitled to $2000.00 of the check. R18 stated the check was deposited by the facility and he never endorsed the check.

On 10/28/08 the facility's Bookkeeper (E20) was interviewed. E20 stated that R18 was told in error that he was entitled to $2000.00 of the Social Security. Per R20 the funds go toward cost of care in the facility.

On interview R18 understood that the monies are to go to the cost of his care at the nursing facility however he stated he never endorsed the check to the nursing facility.

During interview E20 stated it is the procedure of the facility that all social security checks are to be endorsed by the resident who is named on the

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F 159	Continued From page 4 check. A copy of the check was reviewed which showed the R18 did not endorse the check.	F 159		
F 167 SS=C	483.10(g)(1) EXAMINATION OF SURVEY RESULTS A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation and facility staff interviews, the facility failed to ensure that the survey results are posted in a place readily accessible to residents. Findings include: Upon entrance into the facility on 10/27/08, it was determined that the survey results from the previous survey was not posted. It was observed that facility staff had not made the survey results readily accessible to residents in the facility. During an interview on 11/3/08, E9 (receptionist) was asked if she knew where the survey results were kept. E9 stated that the survey results were maintained in a binder behind the receptionist desk. E9 gave the surveyor the binder.	F 167		1/11/09

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F 167	Continued From page 5 Residents had to ask facility staff for the survey results. The facility failed to ensure that the survey results are readily accessible.	F 167		
F 170 SS=C	483.10(i)(1) MAIL The resident has the right to privacy in written communications, including the right to send and promptly receive mail that is unopened. This REQUIREMENT is not met as evidenced by: Based on interviews, the facility failed to ensure that residents promptly receive mail that is delivered to the facility. Findings include: During the Group interview on 10/28/08, 16 of 16 residents stated that there is no mail delivery on Saturdays. According to the residents, there is no staff to sort and distribute the mail on Saturdays. The residents confirmed that Saturday mail is not delivered until late on Monday. During the daily status meeting on 11/30/08, facility staff were informed of the residents concerns regarding no mail delivery on Saturdays. Facility staff did not offer an explanation regarding mail services.	F 170		1/11/09
F 223 SS=K	483.13(b), 483.13(b)(1)(i) ABUSE The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual,	F 223		2/6/09

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F 223	Continued From page 6 or physical abuse, corporal punishment, or involuntary seclusion. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to assure that 2 of 30 sampled residents (R28 & R30) are free of physical abuse. Based on the review of the September incident log the facility failed to have a plan of action or intervention for resident to resident abuse. In review of the incident reports, there was a high number of incidents for the month of September. There was a total of 44 altercations between resident to resident. These failures resulted in an Immediate Jeopardy. E1(Administrator) and E2 (Director of Nurses) were informed of the Immediate Jeopardy on 11/03/08 The Immediate Jeopardy was determined to have begun on 10/19/08 when a Code Yellow (Behavioral Emergency) was called and R28 was roughly handled and dragged down hallway by staff including untrained staff. An Immediate Jeopardy was also determined to have begun on 10/28/08 when a staff person retaliated when R30 became aggressive. The Immediacy was removed on 11/07/08 however the facility remains out of compliance at a severity level 2.	F 223		

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Findings Include:

1. Records indicate that at approximately 11:30p.m. on 10/19/08 1:1's were being done in the day room of seventh floor for R28 and R45. R28 was fighting with staff and trying to hit staff, refusing to stay on 1:1 and wanting to go to his room. R28 was successful in getting back to his room. At 11:30p.m. a Code Yellow (behavioral emergency) was called by E33 (Nurse Aide). E36 (Staff Nurse) was on another unit at time Code Yellow called.
Two security guards responded (E34 & E35). Written statement from E33, E34, and E35 state R28 refusing to get up from bed, clinging to bed frame. R28's mattress was subsequently flipped and R28 was dragged out of room by E34 and E35. Somehow R28's pants fell to either his knees or ankles and R28 was dragged partway down hallway by E34 and E35.

E35's statement indicates that it was E33's idea to flip R28's mattress. Once in hallway R28 again grabbed E35's leg trying to bite him. E35 put his hand between R28s mouth and his leg and finally got R28 off his leg. R28 was carried partially down hall with E35 having R28's top, E34 had legs and R28's behind was on the ground. R28 subsequently walked part of hall to day room.
At time of incident E35 had not been trained in Crisis Prevention Interventions (CPI) and should not have put his hands on a resident.

E34's statement indicates that R28 would not get out of bed. R28's arms had to be pulled off bed by E33, E34 and E35. R28's mattress was flipped and R28 ended on the floor. E34 grabbed his legs and E35 grabbed his arms and we pulled/dragged R28 out of the room. In hall R28

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had a hold on E35 legs. They finally got R28 off E35's leg. E34 was asked how R28's pants got down and E34 stated R28 had loose jogging pants on.

E33's statement of 10/21/08 indicates when she came to work for night shift at 11p.m. on 10/19/08 1:1 was endorsed to her. E36 (Staff Nurse) made decision to have mattresses's pulled into day room for the 1:1 observation. E33 asked R28 if he was aware he was on a 1:1 and R28 said yes. R28 refuses to go to day room and started hollering. E33 called E36 and asked other Nurse Aid (E30) to watch R28 because he could not be left. E33 called the code yellow at 11:30p.m. Security had a hard time getting R28 out of bed. They had to physically move him out of the bed. R28 was saying they are hurting me. It took about 30 minutes, E36 came to floor and R28 went to the day room. During Code R28 was kicking, scratching and biting.
E33's statement of 10/23/08 indicates she told R28 the nurse wanted him to go to the dayroom and he would not go. Another Nurse Aide was asked to tell the Nurse. E30 (Nurse Aide) called the Code Yellow. Further statements indicate someone else notified security. Security guards responded. R28 was holding on to bed. Security was trying to get him off bed. Somehow R28 rolled off bed. He was trying to kick and bite. R28 was dragged out of room. R28 was holding onto the wall. E33 said 'you may have to stop.' By that time R28's clothes were off. E36 (Nurse) came and talked to R28. R28 then got up and walked to dayroom. E33 then brought R28's mattress to day room.
During this interview E33 was asked if she felt security was rough with R28 why she did not report it. E33 then stated 'maybe they were not

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rough.' E33 was asked how security was dragging R28. E33 stated 'one had him by the arms and one had him by the legs.' E33 was asked if that was acceptable. E33 stated 'No, I do not.'
E33 was asked if R28 said anything after the ordeal was over. E33 stated R28 asked for popcorn and said look what security did to me. E30 called the nurse who did not come right away until someone said he would tell Administrator. Nurse looked at R28 and said 'it doesn't look like a a new bruise.'

Nurse note (E36) dated 10/20/08 at 1:40a.m. states 'R28 showed writer right forearm inner area with reddish mark.. R28 stated security hurt me. No complaints of pain, area cleansed with normal saline, on 1:1 in day room.
No further body checks were documented done by E36.

E33 did not report rough handling nor dragging a resident down hallway as suspected abuse.

E36 did not report R28's allegation that security hurt him.

E33 and E36 both worked the following night shift.

2. On 10/29/08 at approximately 9:15a.m. E1 (Administrator) presented surveyors a preliminary investigation of an alleged physical abuse of staff (E37) to resident (R30) on 10/28/08. During interview E1 stated R30 allegedly threw her keys at a staff nurse. E1 stated investigation at that point shows that nurse raised her hand to protect herself.

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At approximately 1p.m. R30 requested to speak to surveyor. R30 was in the third floor nurse station with several staff including nurses and psycho-social rehab staff. R30 was very agitated about what happened on 10/28/08. R30 stated she had gotten into an altercation with another resident because she was call a racial slur. R30 stated she had threw her keys at a nurse and the nurse grabbed her throat. R30 was observed to have a 3 to 4 inch reddened mark on her neck. R30 became very agitated, a behavioral emergency was announced, R30 was medicated for behavior and subsequently sent to the hospital.

Surveyor requested any investigation of incident of 10/28/08. E1 presented several statements made by staff/residents who witnessed the altercation on 10/28/08.

Statements by E10, E11 and E28, PRSC's (Psychiatric Rehab Services Coordinators) reveal that E37 was involved in a verbal and physical altercation with R30 and E37 had to be pulled away from the situation.

There was no statement made by E37 presented to surveyor. E2 (Director of Nurses) presented surveyor with documents of events for 10/28/08 and 10/29/08. One document states E37 was asked to report to the Human Resources Department (HR) after incident on 10/28/08. E37 refused to enter HR Department and walked out of the facility.

After incident on 10/28/08 a physician order was obtained at 6:15p.m. to send R30 to the hospital for medical clearance. During interview E2 stated medical clearance was for possible injury

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to R30. This order was not followed and R30 was not sent to hospital on 10/28/08.

The Facility took the following actions to remove the Immediate Jeopardy:

1. On November 4, 2008 all current staff, who are not CPI certified will be in-serviced that they are prohibited from putting hands on residents, except to assist with activities of daily living.

2. A full CPI curriculum program was on offered by 11/07/08

3. In-service on Abuse Prevention was given on 11/03/08. In-services were completed 11/07/08.

4. Management staff were in-serviced regarding increased sensitivity for possible abuse/neglect signs or symptoms 11/04/08.

5. An outside consultant in-serviced regarding increased sensitivity for possible abuse/neglect signs or symptoms 11/04/08.

6. Reports of possible abuse/neglect can be collected from but not limited to: observation, self-report, written report, incident reports, grievance reports, and Resident Council minutes. These shall be immediately reported to the Abuse Prevention Coordinator. The Abuse Prevention Coordinator will determine whether to initiate an abuse investigation. He will then assign the investigation to a trained investigator who will complete the entire investigation.

7. The Abuse Prevention Coordinator will make a final review of all abuse investigations using the Illinois council on Long Term Care Abuse

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F 223	Continued From page 12 Prevention Program. 8. Time constraints for preliminary investigation, investigation and final investigation reports will be in compliance with the Department's regulations. 9. All facility episodes requiring physical intervention will be reviewed by a CPI certified instructor to ensure appropriate techniques were utilized. A summary report will be prepared and presented the the Quality Assurance Committee monthly. 10. All assigned investigations will be reviewed by the Abuse Prevention Coordinator and/or designee for the following: preparation, confidentiality, review of abuse definitions, choice of investigation path, investigation procedures, interview process and final investigation report. A summary report will be prepared and presented to the Quality Assurance committee monthly.	F 223		
F 224 SS=J	483.13(c) STAFF TREATMENT OF RESIDENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on record review and interviews facility staff neglected to provide necessary care/interventions to prevent an attempted suicide for 1 of 30 sampled residents (R28) who told staff he wanted to kill himself and was eventually found supine in a bathtub with a shoestring around his neck which was tied to the water faucet.	F 224		2/6/09

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F 224	Continued From page 13 This failure resulted in an Immediate Jeopardy. E1(Administrator) and E2 (Director of Nurses) were informed of the Immediate Jeopardy on 10/30/08. The Immediate Jeopardy was determined to have begun on 10/07/08 when R28 informed staff he wanted to kill himself and adequate preventive measures were not implemented. The Immediacy was removed on 11/02/08 however the facility remains out of compliance at a severity level 2. Findings Include: R28's diagnoses include schizoaffective disorder. R28 has a history of suicidal ideations with attempts at self harm. Record shows the most recent attempt at self harm was 09/25/08 when R28 cut right arm with a razor blade and stated he did not want to live anymore. R28 was hospitalized at that time. Nurses notes dated 10/07/08 at 11:30p.m. state 'R28 tearful, indicated to staff that he wanted to kill himself. Refused medication, stating they don't work. R28 able to be redirected' On 10/08/08 at 1a.m. notes stated a call was received from a local hospital stating that R28 had called them wanting to be picked up. Notes indicate that R28 was put on 15 minute checks at this time. Note at 2:15a.m. states found R28 lying in tub in supine position with shoestring around neck tied to water faucet. R28 stated 'I told you I'm going to kill myself.' Vital signs taken and stable, no	F 224		

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injury to neck.
Note at 2:30a.m. states Assistant Director of Nurses (ADON) and Psychiatric Rehab Services Coordinator (PRSC) called to advise of situation. Physician was also paged.
Note at 2:45a.m. states physician ordered R28 to emergency room for psych evaluation. At 3:45a.m. R28 was transported to the hospital and emergency contact notified.

Facility policy for Suicidal Behavior states all suicidal ideations and/or behaviors are considered to be potentially dangerous. In instances of suicide threats there must be an assessment of the situation, the danger the situation presents to the resident, its immediacy, and the probability of its being carried out.
Policy also states that a staff member hearing or observing a verbal threat, comment, gesture, or hallucination must stay with the resident and respond as appropriate to the situation. Under no circumstances leave the resident alone.
Policy states when the issue is a verbal threat employee must notify the resident's PRSC, the Director of Resident Services (RSD) and the Director of Nursing (DON) or designees (supervisors designated to be on call.) The Director of Resident services or the Director of Nursing or designee must assess the potential dangers of the incident and contact the resident's physician of psychiatrist with recommendations.
Policy states the Charge Nurse is to complete and Accident/Incident Report following all appropriate procedures.

E2 (DON) was interviewed on 10/30/08 and stated she was never made aware of this situation involving R28 on 10/07/08.

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There is no evidence staff followed policy for Suicidal Behavior by conducting any assessment when R28 made a verbal threat of suicide on 10/07/08 at 11:30p.m.
There is no evidence staff stayed with R28 to assure that he did not act on threat.
There is no evidence staff followed policy of notifying PRSC, RSD or DON of the situation for further direction.
There is no evidence an Accident/Incident Report was completed.

The Facility took the following actions to remove the Immediate Jeopardy:

1. Inservices of all active clinical staff on the procedure for managing residents who present with suicidal ideations. Training will include the following components:

a. Placing resident on 1:1 for safety when any suicidal behavior is expressed. During 1:1 checks, staff must be within an arms length of the resident at all times.
b. Review of procedure of what to do if a resident becomes suicidal.
c. The clinical supervisor on call and the resident's psychiatrist will be notified as soon as practical once the resident's immediate safety has been established.
d. Residents on 1:1 checks will be monitored until such time that the clinical manager, in consultation with the psychiatrist, determines that the resident no longer require 1:1 monitoring.

Inservices of all active clinical staff were completed 11/02/08.

2. The facility will monitor by the use of an

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F 224	Continued From page 16 observation check Quality Assurance Sheet to be completed for every resident on observation on a daily basis. This will be reviewed by the DON or Clinical Manager daily. Any deficiencies identified will be corrected. This may include staff training and progressive discipline if needed. This data will be compiled, summarized and reviewed by the DON and/or PRSC on a daily basis. 3. The facility identifed all resident in the facility with suicidal ideations, suidical attempts, and/or self harm. 135 resident were identified. All care plans were updated on 10/31/08. Resident specific problems were identified and approaches were developed. These were presented to surveyors on 11/02/08.	F 224		
F 225 SS=J	483.13(c)(1)(ii)-(iii), (c)(2) - (4) STAFF TREATMENT OF RESIDENTS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures	F 225		2/6/09

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(including to the State survey and certification agency).

The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.

The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

This REQUIREMENT is not met as evidenced by:
Based on interviews and record review the facility failed to assure that staff immediately report allegations of mistreatment or abuse.
The facility also failed to assure that alleged violations are thoroughly investigated and appropriated corrective action is taken.

These failures resulted in an Immediate Jeopardy.

E1(Administrator) was informed of the Immediate Jeopardy on 11/26/08

The Immediate Jeopardy was determined to have begun on 10/19/08 when a Code Yellow (Behavioral Emergency) was called and R28 was roughly handled and dragged down hallway by staff, including untrained staff.

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F 225	Continued From page 18 The Immediacy was removed on 11/26/08 however the facility remains out of compliance at a severity level 2. Findings Include: 1. Records indicate that at approximately 11:30p.m. 1:1's were being done in the day room of seventh floor for R28 and R45. R28 was fighting with staff and trying to hit staff, refusing to stay on 1:1 and wanting to go to his room. R28 was successful in getting back to his room. At 11:30p.m. a Code Yellow (behavioral emergency) was called by E33 (Nurse Aide). E36 (Staff Nurse) was on another unit at time Code Yellow called. Two security guards responded (E34 & E35). Written statement from E33, E34, and E35 state R28 refusing to get up from bed, clinging to bed frame. R28's mattress was subsequently flipped and R28 was dragged out of room by E34 and E35. Somehow R28's pants fell to either his knees or ankles and R28 was dragged partway down hallway by E34 and E35. E35's statement indicates that it was E33's idea to flip R28's mattress. Once in hallway R28 again grabbed E35's leg trying to bite him. E35 put his hand between R28s mouth and his leg and finally got R28 off his leg. R28 was carried partially down hall with E35 having R28's top, E34 had legs and R28's behind was on the ground. R28 subsequently walked part of hall to day room. At time of incident E35 had not been trained in Crisis Prevention Interventions (CPI) and should not have put his hands on a resident. E34's statement indicates that R28 would not get	F 225		

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out of bed. R28's arms had to be pulled off bed by E33, E34 and E35. R28's mattress was flipped and R28 ended on the floor. E34 grabbed his legs and E35 grabbed his arms and we pulled/dragged R28 out of the room. In hall R28 had a hold on E35 legs. They finally got R28 off E35's leg. E34 was asked how R28's pants got down and E34 stated R28 had loose jogging pants on.

E33's statement of 10/21/08 indicates when she came to work for night shift at 11p.m. on 10/19/08 1:1 was endorsed to her. E36 (Staff Nurse) made decision to have mattresses's pulled into day room for the 1:1 observation. E33 asked R28 if he was aware he was on a 1:1 and R28 said yes. R28 refuses to go to day room and started hollering. E33 called E36 and asked other Nurse Aid (E30) to watch R28 because he could not be left. E33 called the code yellow at 11:30p.m. Security had a hard time getting R28 out of bed. They had to physically move him out of the bed. R28 was saying they are hurting me. It took about 30 minutes, E36 came to floor and R28 went to the day room. During Code R28 was kicking, scratching and biting.
E33's statement of 10/23/08 indicates she told R28 the nurse wanted him to go to the dayroom and he would not go. Another Nurse Aide was asked to tell the Nurse. E30 (Nurse Aide) called the Code Yellow. Further statements indicate someone else notified security. Security guards responded. R28 was holding on to bed. Security was trying to get him off bed. Somehow R28 rolled off bed. He was trying to kick and bite. R28 was dragged out of room. R28 was holding onto the wall. E33 said 'you may have to stop.' By that time R28's clothes were off. E36 (Nurse) came and talked to R28. R28 then got up and

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walked to dayroom. E33 then brought R28's mattress to day room.
During this interview E33 was asked if she felt security was rough with R28 why she did not report it. E33 then stated 'maybe they were not rough.' E33 was asked how security was dragging R28. E33 stated 'one had him by the arms and one had him by the legs.' E33 was asked if that was acceptable. E33 stated 'No, I do not.'
E33 was asked if R28 said anything after the ordeal was over. E33 stated R28 asked for popcorn and said look what security did to me. E30 called the nurse who did not come right away until someone said he would tell Administrator. Nurse looked at R28 and said 'it doesn't look like a a new bruise.'

Nurse note (E36) dated 10/20/08 at 1:40a.m. states 'R28 showed writer right forearm inner area with reddish mark.. R28 stated security hurt me. No complaints of pain, area cleansed with normal saline, on 1:1 in day room.
No further body checks were documented done by E36.

E33 did not report rough handling nor dragging a resident down hallway as suspected abuse.

E36 did not report R28's allegation that security hurt him.

E33 and E36 both worked the following night shift.

2. A complete and thorough investigation of above stated events including corrective action was not done.
A summary of events was never completed. For

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example the nurse on duty (E36) covered two units the night of the above stated events. Investigation does not address that the E36 was not on the unit when the Code Yellow was called regarding R28. Summary does not address that on a unit of approximately 75 residents two Nurse Aides were scheduled for the night shift and two residents were on 1:1 observations.
Corrective action was to include training of non-trained security staff in Crisis Prevention Interventions. This was not implemented until after the facility was informed of the Immediate Jeopardy.

The Facility took the following actions to remove the Immediate Jeopardy:

-An outside consultant provided a directed in-service on conducting a complete and thorough investigation of abuse and neglect allegations on 11/26/08.
The in-service will provide management staff the ability to conduct investigations that will (a) provide a clear picture of the alleged incident, (b)provide a list of all employees, resident's and/or witnesses that had the potential to have known about the alleged incident, (c) provide a clear timeline of events of alleged incident, (d) provide a complete and comprehensive summary of the incident, (e)provide management the opportunity to identify potential areas for employee education, employee disciplinary action, and/or review of systems, policy or procedures.

-All staff were in-serviced on Abuse/Neglect and that failure to intervene and/or report abuse/neglect is abuse and is a terminal offence.

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F 225	Continued From page 22 -Reports of possible abuse/neglect can be collected from but not limited to: observation, self-report, written report, incidents reports, grievance reports, and Resident Council minutes. These shall be immediately reported to the Abuse Prevention Coordinator. The Abuse Prevention Coordinator will determine whether to initiate an abuse investigation. He will then assign the investigation to a trained investigator who will complete the entire investigation. -The Abuse Prevention Coordinator will make a final review of all abuse investigations using the Illinois Council on Long-Term Care Abuse Prevention Program. -Time constraints for preliminary investigation, investigation and final investigation reports will be in compliance with with Illinois Department of Public Health Regulations. -All assigned investigations will be reviewed by the Abuse Prevention Coordinator and/or designee for the following: preparation, confidentiality, review of abuse definitions, choice of investigation path, investigation procedure, investigation process, and final investigation reports. A summary report will be prepared and presented to the Quality Assurance Committee monthly.	F 225		
F 226 SS=G	483.13(c) STAFF TREATMENT OF RESIDENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced	F 226		2/6/09

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by:
Based on record review and interviews the facility failed to implement policies and procedures that protect resident from abuse and mistreatment. The facility failed to assure that staff are adequately trained in responding to behavioral emergencies, failed to have staff on each shift in sufficient numbers to meet the needs of the residents, failed to adequately supervise staff to prevent rough handling, failed to assure staff report all alleged violations, and take all necessary corrective actions depending on the results of the investigation;

Findings Include:

1. Records indicate that at approximately 11:30p.m. 1:1's were being done in the day room of seventh floor for R28 and R45. R28 was fighting with staff and trying to hit staff, refusing to stay on 1:1 and wanting to go to his room. R28 was successful in getting back to his room. At 11:30p.m. a Code Yellow (behavioral emergency) was called by E33 (Nurse Aide). E36 (Staff Nurse) was on another unit at time Code Yellow called.
Two security guards responded (E34 & E35). Written statement from E33, E34, and E35 state R28 refusing to get up from bed, clinging to bed frame. R28's mattress was subsequently flipped and R28 was dragged out of room by E34 and E35. Somehow R28's pants fell to either his knees or ankles and R28 was dragged partway down hallway by E34 and E35.

At time of incident E35 had not been trained in Crisis Prevention Interventions (CPI) and should not have put his hands on a resident.

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E33 was asked if R28 said anything after the ordeal was over. E33 stated R28 asked for popcorn and said look what security did to me. E30 called the nurse who did not come right away until someone said he would tell Administrator. Nurse looked at R28 and said 'it doesn't look like a a new bruise.'

Nurse note (E36) dated 10/20/08 at 1:40a.m. states 'R28 showed writer right forearm inner area with reddish mark.. R28 stated security hurt me. No complaints of pain, area cleansed with normal saline, on 1:1 in day room.
No further body checks were documented done by E36.

E33 did not report rough handling nor dragging a resident down hallway as suspected abuse.

E36 did not report R28's allegation that security hurt him.

E33 and E36 both worked the following night shift.

A complete and thorough investigation of above stated events including corrective action was not done.
A summary of events was never completed. For example the nurse on duty (E36) covered two units the night of the above stated events. Investigation does not address that the E36 was not on the unit when the Code Yellow was called regarding R28. Summary does not address that on a unit of approximately 75 residents two Nurse Aides were scheduled for the night shift and two residents were on 1:1 observations.

2. On 10/29/08 at approximately 9:15a.m. E1

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F 226	Continued From page 25 (Administrator) presented surveyors a preliminary investigation of an alleged physical abuse of staff (E37) to resident (R30) on 10/28/08. During interview E1 stated R30 allegedly threw her keys at a staff nurse. E1 stated investigation at that point shows that nurse raised her hand to protect herself. At approximately 1p.m. R30 requested to speak to surveyor. R30 was in the third floor nurse station with several staff including nurses and psycho-social rehab staff. R30 was very agitated about what happened on 10/28/08. R30 stated she had gotten into an altercation with another resident because she was call a racial slur. R30 stated she had threw her keys at a nurse and the nurse grabbed her throat. R30 was observed to have a 3 to 4 inch reddened mark on her neck. R30 became very agitated, a behavioral emergency was announced, R30 was medicated for behavior and subsequently sent to the hospital. Surveyor requested any investigation of incident of 10/28/08. E1 presented several statements made by staff/residents who witnessed the altercation on 10/28/08. Statements by E10, E11 and E28, PRSC's (Psychiatric Rehab Services Coordinators) reveal that E37 was involved in a verbal and physical altercation with R30 and E37 had to be pulled away from the situation. There was no statement made by E37 presented to surveyor. E2 (Director of Nurses) presented surveyor with documents of events for 10/28/08 and 10/29/08. One document states E37 was asked to report to the Human Resources	F 226		

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F 226	Continued From page 26 Department (HR) after incident on 10/28/08. E37 refused to enter HR Department and walked out of the facility. 3. Refer to F353 Sufficient nursing staff to provide services.	F 226		
F 241 SS=E	483.15(a) DIGNITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain and respect resident's private space by entering resident's rooms without resident's permission. Based on direct observations, it was determined that the facility failed to 1) Use regular dishware 2) Assist resident with their clothing. Findings include: 1. During initial facility tour on 10/27/08 on the 5th floor with E12 (Psychosocial Rehabilitation Supervisor), E12 was observed to be knocking on doors and announcing as stated "Staff ", entered to all these rooms (501 to 531) without waiting for the resident's response or permission. 2. On 10-29-08 at the Luncheon meal, the facility was using Styrofoam bowls for the peaches. 3. On 10-28-08 at the breakfast meal, R27 was observed walking to the table in the Dining Room	F 241		1/11/09

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F 241	Continued From page 27 where she was observed to have her blouse torn from the back sleeve around to the back of the blouse, bra strap was exposed. On 10-27-08 R26 was observed with holes in the front of her skirt and back of skirt also R44 with a dirty shirt on the front side and both sleeves. 4. R21 stated when interviewed on 10/29/08 at 11:45am the staff do not always knock, and if they do, they just walk in the door and do not wait for an answer. R21 also stated that he feels that his privacy is not respected by staff or other residents. During the interview with this resident, a staff person did enter the room without waiting for an answer after knocking.	F 241		
F 248 SS=E	483.15(f)(1) ACTIVITIES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based upon observations, record review and interviews the facility failed to ensure that 4 of 30 residents in sample (R4, 12, 13 & 14) and other residents received activities services based upon their individual interests. Findings include: The facility recreational calendar provided denotes in part the following activities: 10/28/08: 9:30- Arts and Crafts	F 248		1/11/09

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F 248	Continued From page 28 2:00-OUTBURST (Game) 10/29/08:11:00-Stretch Exercise 2:00-Movies (Floors 3, 4, 6, 7 and 8) During the following times as indicated above the third and sixth floors did not have an assigned staff to initiate activities in the dayroom area. In addition, R's 4, 12,13,and 14 did not participate, or have individualized activities provided in their rooms. E17(Activity Director) was interviewed on 10/30/08 and stated," When activity staff not on the 9th. floor, they come to other floors...we do not have 1 to 1's list of activities, or provide activities in room." On the following survey dates 10/27, 10/28 and 10/29/08 during morning and afternoon hours, residents were observed seated in the 5th floor main day area with TV (television) on. There was no structured activity that occurred during these three days of the survey. On 10/30/08 at 10:00AM, low impact exercise program was observed initiated by an activity aide, there was some 21 to 23 residents in this day area, and in approximately 5 to 12 minutes there was only 5 residents left in the day area. Residents were observed walking out of the day area one by one. There was no staff intervention to encourage residents to stay for the exercise program.	F 248		
F 250 SS=D	483.15(g)(1) SOCIAL SERVICES The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial	F 250		1/11/09

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F 250		F 250		

Continued From page 29
well-being of each resident.

This REQUIREMENT is not met as evidenced by:
Based on record review and interview the facility failed to provide discharge planning for 2 of 30 sampled residents (R21 and R27).

Findings Include:

1. R27 on all days of the survey constantly complained that she wanted to go to another facility. In review of the medical record, record did indicate that R22 had gone to another facility with a family member a month ago and was accepted at that facility. On 10/30/08 with E22 (PRSC) at 10:10 a.m. revealed that R27 did sign a release to go to another facility. E22 stated that R27 keeps changing her mind and refuses to go to another facility. In review of the social service notes and other notes, there is no indication that R27 refusals. At 10:30 a.m. E22 stated that he could not produce any information per refusals by R27.

2. R21 stated when interviewed on 10/28 at 10:30am that he wants to leave the facility and needs help with discharge planning. " No one will give me help; I thought this was a detox unit. "

Review of R21's MDS (Minimum Data Set) dated 10/3/08 scores "0" under cognition (no deficits).

Review of the clinical record shows that no discharge planning has been started or discussed with the resident. R21 has been a

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F 250	Continued From page 30 resident for 6 months. Interview with E24 on 10/29 at 11:10am revealed that no planning has been started. E24 stated that the resident is non compliant with medications, is restricted to the facility because of alcohol abuse, and refuses to see the physician. The goal is to encourage the resident to comply and join in house activities. E24 does not believe the resident is ready for discharge even though the resident has been asking about it.	F 250		
F 252 SS=E	483.15(h)(1) ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observations, the facility failed to provide a safe, clean, and homelike environment to the residents. Findings include: On the initial tour of the facility from approximately 9:45 to 11:45 A.M. on Oct. 27, 2007, the following conditions were noted, as observed, in the resident rooms and common areas: 1. Many residents toilet rooms were observed with floors caked with dirt especially on the sides and corners. Examples: rooms 401, 4th. floor men's common toilet/shower, the 2 sinks in the men's common toilet/shower, 413, 411, 415, 529,	F 252		1/11/09

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F 252	Continued From page 31 518, 429, 823, 825, 826, 819, 829, 830, 832, 8th. floor men's common toilet room/lounge, 801, 802, 808. Strong urine odor in room 411503, 5th. floor men's common toilet room, in 508; musty odor in room 529, and 526. Heavily soiled call light cords in toilet stall no. 2 in men's common toilet room 4th. floor, 2. Cigarette butts were on the floor in room 824; cigarette ashes on the floor in the men's common toilet room on the eight floor and in room 829. 3. Clutter/ clothes all over the room and draped on chairs/on the floor/at bottom of the closets in room 501, 503, 513, 512, 509, 515, 531, 530, 529, 518, 525, 523, 401, 429, 406. 4. Unlabelled urinals and toothbrushes in rooms 503, 513, 507, 529, 519. 5. Passenger elevators with accumulation of debris along the tracks. Thick dirt covered the floor of the freight elevator. The laundry room floor is also not clean especially along the sides and corners. 6. On 10/28/08 1) Room 426, (R27) numerous pairs of shoes surrounding bed. black mold around tub. 2) Room 622 (R1) bags of clothing on the floor. 3) Room 708 (R7) closet cluttered, dresser drawers packed with clothing. 4) Room 724 (R6) coats on hangers hanging from privacy curtain. Dresser drawers and closet	F 252		

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F 252	Continued From page 32 stuffed with clothing. 7. On 10/29/08 Room 616 bags of clothes on the floor of the closet. 8. On 11/03/08 At 10:40 a.m The Smoking Room on the 1st floor was observed with thick smoke and dim lighting.	F 252		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations, the facility did not provide housekeeping and maintenance services necessary to maintain a sanitary and orderly condition in all the resident areas. Findings include: During the initial tour of the facility on 10-27-08 which started at approximately 9:45 A.M, the following conditions were observed and noted: 1. A handwashing sink in room 429 was stopped up and was covered by a transparent plastic material. The wall by the tub was rutted and had a mold like, black substance. The shower curtain had a black residue at the bottom of the curtain. There is a big hole, around 3/4 size of a basketball, on the wall by the side of bed - 1. The door to the washroom was dragging. 2. The shower curtain rod was missing in room 411; there is no privacy curtain for the resident in	F 253		1/11/09

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F 253	Continued From page 33 room 415-2.; the privacy curtain was not hung in room 429-3 because the hooks were missing; 3. A large garbage container had garbage filled to the top; uncollected garbage in resident rooms 404 and 408. 4. Unmarked/unlabelled urinals in multiped rooms 529, 507, 503, 513. Dirty, brown colored water on the floor of the toilet room in 529; the toilet in 518 had mold like substance with brown stains; the baseboard is missing in the bathroom of 509. Stuffed animals and plastic materials were placed on top the radiator in room 512; jagged/rough handrails observed all over the 5th. floor; exposed radiator observed in room 508. 5. The call light in the men's common shower 4th. floor was not working and the call cord was too short in toilet stall no. 1 and also wobbly toilet seat. The two sinks in this room were both dirty; there is no hot water supply in the toilet room, a dripping faucet at the tub, and no light switch to turn the light on and off in 401 6. On 10-28-08 - Room 426 (R27) the bathroom tub and walls had mold on it. - Room 622 (R1) the ceiling fan was loose and wobbly also having brown stains on blades and no closet door. Faucet in the bathroom was leaking, dim lighting, walls dirty and floor not cleanable. - Room 616, ceiling fan was wobbly and loose. - Room 708 dim lighting, stains on toilet lid, walls	F 253		

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F 253	Continued From page 34 dirty, missing tiles on the wall and bathtub dirty.	F 253		
F 255 SS=B	483.15(h)(4) ENVIRONMENT- CLOSET SPACE The facility must provide private closet space in each resident room, as specified in §483.70(d)(2)(iv) of this part. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to ensure that each resident is provided with a private closet space. Findings include: 1. On 10/30/08, R11 was observed to have her clothing hanging over the closet doors. During an interview, R11 stated that she does not have a rack inside the closet to hang her garments; and that the inside of the closet is so "disgusting" and that she refuses to put her things inside. The inside floor of the wardrobe cabinet, was observed with an excessive accumulation of dirt, debris and large pieces of paint chips. The doors of the wardrobe cabinet were observed with multiple layers of peeling paint; and the inside drawers were painted shut. R11 was not provided with adequate closet space. 2. The facility census and roster presented by staff, indicated that room 831 was occupied by four residents. During the tour on 10/27/08, it was determined that there were only 2 closets in room 831. The facility failed to provide closet space for each of the residents in room 831. 3. According to the facility layout and resident census presented by E1 (administrator), room	F 255		1/11/09

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F 255	Continued From page 35 823 is occupied by four residents. During the initial tour on 10/27/08, it was determined that there were only three closets in this room. The facility failed to ensure that each resident in a room has an assigned closet space. 4. The following residents had closets that did not provide enough space. R1, R26 and R7.	F 255		
F 272 SS=D	483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and	F 272		1/11/09

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Documentation of participation in assessment.

This REQUIREMENT is not met as evidenced by:
Based on observations, record review and interviews, the facility failed to complete a comprehensive resident assessment for 3 of 30 sampled residents (R11, R20 and R21). This resulted in the facility's failure to determine the need for services in the areas of nutrition (R11), pain management (R21) and assistive devices (R20).

Findings include:

1. R11 is a 29 year old resident who was admitted to the facility on 5/19/08 with diagnoses including bipolar disorder, eating disorder and attention deficit hyperactivity disorder. On review of the most recent resident assessment instrument (Minimum Data Set) dated 6/9/08, facility staff failed to address nutritional concerns, as it relates to the resident's eating disorder.

On review of the clinical record, it was determined that the initial Nutritional Assessment completed by the diet tech on 5/23/08, did not identify the type of eating disorder for R11. In addition, there were no recommendations for nutritional approaches. According to the assessment, R11 was "slightly above ideal body weight." This was not an accurate assessment, as facility staff did not obtain the resident's weight on admission.

On 5/28/08, the registered dietitian documented that the assessment completed by the diet tech was acceptable. The assessment completed by

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the registered dietitian did not address the resident's eating disorder. According to the registered dietitian, R11 had no problems with her weight.

Facility staff documented on the Monthly Weights and Vitals sheet on 5/19/08, that R11 had a weight of 135 pounds. According to the Minimum Data Set completed by facility staff on 6/9/08, R11 had a weight of 119 pounds. The documentation indicates that R11 had a weight loss of 16 pounds in three weeks. There was no documentation to support that facility staff addressed any issues related to the resident's weight. In addition, there was no documentation to support that facility staff obtained baseline weights for R11.

According to the resident assessment dated 6/9/08, facility staff documented that R11 had no weight changes and no identified nutritional problems. In addition, facility staff indicated that there was no need for any additional nutational approaches for R11.

R11 was admitted to the facility with an eating disorder. Facility staff failed to complete a comprehensive nutritional assessment, in an effort to determine the resident's needs related to her eating disorder. This resulted in the facility's failure to provide the necessary services for a resident with an eating disorder.

2. R20 was admitted to the facility on 1/31/08 with diagnoses including schizoaffective disorder, psychosis, asthma, hypertension diabetes mellitus and seizure disorder. R20 was observed to have a deformity to the left foot. The resident was missing most of the left heel. During an

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F 272	Continued From page 38 interview on 10/29/08, R20 stated that he sustained a foot injury while serving in the military. R20 stated that he has a gait disturbance as a result of the injury. R20 further stated that he had a cane when he was admitted to the facility, but facility staff took the cane from him. During an interview on 10/29/08, E18 (Nurse) confirmed that R20 did not have a cane. According to E18, R20 attempted to hit staff with his cane and his cane was taken from him. According to E18, the resident never had an order for a cane. On review of the most recent Physician's Order Sheet dated 9/30/08, R20 had a physician's order that stated he, "may have cane for ambulation." R20 also had a physician's order for a left ankle splint. During observations on 10/27/08 to 10/29/08, R20 was no observed to have a walking cane or a splint. On review of the clinical record, there was no assessment addressing the resident's mobility status. Neither was there any documentation addressing the resident's walking cane or the splint. Facility staff failed to assess the resident to determine the need for assistive devices and/or appliances to improve his ambulatory status. 3. A review of R21's physician orders show that he has an order for Vicodin 5/500 every 6 hours for pain. No pain assessment was found. Documentation in the nursing notes dated 6/13/08 & 6/20/08 states that the resident complained of a headache. No further documentation was found regarding the continued use of this drug, or of the resident's	F 272		

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F 272	Continued From page 39 pain level. R21 received 21 doses of Vicodin in August and 15 doses in June of 2008.	F 272		
F 276 SS=E	483.20(c) QUARTERLY REVIEW ASSESSMENT A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, the facility failed to provide quarterly MDS for 11 of 30 sampled residents. (R1, 2, 6, 7, 10, 11, 15, 16, 20, 24, & 26) Findings Include: 1) R1 last MDS done on 10/3/07, R6 last MDS done on 3/08, R26 last MDS was done on 2/08 and R7 last MDS was done on 5/9/08. 2. On review of the clinical record for R10, it was determined that the facility had not completed a quarterly resident assessment. The most recent resident assessment instrument was dated 6/2/08. During interviews on 10/28/08, facility staff were asked to present the assessment for review. Facility staff did not present a quarterly resident assessment. 3. On review of the clinical record, R11 had a quarterly assessment dated 6/9/08. The next resident assessment should have been complete by September 2008. Facility staff were not able to present the resident assessment on request. Facility staff failed to ensure that resident assessments are completed.	F 276		1/11/09

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F 276	Continued From page 40 4. On review of the clinical record for R20, it was determined that the most recent resident assessment instruments were not maintained in the active record. The clinical record did not contain the last annual or the most recent quarterly resident assessment. Facility staff were not able to present the assessments on request. 5. Record review showed that R2 had an original admission date of 12-11-03. The last annual MDS (Minimum Data Set) was dated 2-26-08 and the last quarterly assessment was done on 5-29-08. No other assessments could be found in R2's clinical records. When E4-LPN (Licensed Practical Nurse-4th. floor)was asked, E4 consequently asked for the most recent MDS from the person responsible for the MDS's. No other MDS's was able to be produced. Other residents who did not have their quarterly assessments, after repeated requests, were R15 (last assessment= 4-1-08), R16 (last assessment-1-8-08), and R24 (last assessment=6-4-08).	F 276		
F 280 SS=E	483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's	F 280		1/11/09

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F 280	Continued From page 41 needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review care plans are not always updated when changes occur for 16 of 30 sampled resident's (R1, 2, 3, 6, 8, 9, 11, 15, 16, 18, 20, 21, 22, 24, 26, & 27). Findings Include: 1. Last Care Plan was done on 2/27/08 for R26. 2. Last Care Plan was done on 3/8/08 for R6. 3. Last Care Plan was done on 1/23/08 for R1 4. Last Care Plan was done on 5//08 for R27. 5. R15's history of substance abuse with cocaine as R15's drug of choice. The facility wrote three goals for R15 with a goal date of 1-01-08 which are as follows: - Resident will practice and maintain sobriety; - Resident will attend MISA groups, as ordered; - Resident will inform staff when she feels the need to use. It showed, upon thorough review, that the facility did not review or revise the Care Plan for R15 since 1-01-08 and that R15 still had episodes of substance abuse since admitted into the facility in	F 280		

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2007. According to the nurses' notes dated 10-10-08, R15 was caught by a staff, during P.M. rounds, in possession of cocaine (in her hands) including the pipe. R15 became aggressive and hostile and turned all the tables in the dining room over. As a consequence, R15 was taken to a psych hospital emergency room. R15 was readmitted into the facility on 10-15-08.

On 10-28-08, E13 (Director of PRSC-4th. floor), was not able to produce, when asked, a new contract which contained the facility's policy regarding AWOL/safety. This contract specified the prohibited use, in the facility, of substances including cocaine. More nurses' notes, dated 10-23 and 10-24-08, indicated R15 as randomly exhibiting agitation and had received antipsychotic medication during each episodes. No revision of the care plan or new interventions was developed by the facility to this date.

6. R2 was admitted to the facility on 12-18-03. A comprehensive Care Plan was developed for R2's use of alcohol with a goal date of Aug.1, 2008. Nurses' notes, dated 7-9 and 7-10-08, showed that R2 admitted to the use of alcohol and had an incident, while intoxicated, on 7-10-08. No new approaches or goal date was set by the facility.

7. R16 has diagnoses that include schizoaffective disorder with behavioral problems such as combativeness, aggression, and physical abusiveness. Nurses' notes, dated 1011-08, 10-25-08, 10-27-08 and 10-28-08, indicated incidents in which R16 exhibited physical abusiveness to a staff and another occasion when R16 actually hit a staff on the stomach. The notes also described R16 as

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F 280	Continued From page 43 delusional with loud outburst, not re-directable and verbally abusive to staff and other residents in a threatening manner. R16 has a history of refusing medication because of R16's lack of insight into need for medication when off her baseline. The last Care Plan goal date, according to chart review, was dated 4-7-08. The facility did not review or revise all the Care Plans since that date. Other Care Plans included the use of crack cocaine, violence, suicidal ideations and attempts (not shown any signs since admission in November of 2007). 8. R24 has a history of physical aggression and also a history of arrest in 1980. Chart review showed that the facility did not have current Care Plans for R24 and that the most recent one was dated 6-4-08. 9. R18 was admitted to the facility on 03/27/08. Care plan in file was dated 04/18/08. Currently R18 is actively seeking discharge from facility. Discharge is not identified in care plan. R18 currently participated in the facility work program. This program is not addressed in care plan. 10. R21 has a history of refusing to see the physician and refusing to attend programs. No care plan was found that addressed these issues. R21 ' s MDS (Minimum Data Set) dated 10/3/08 and 7/3/08 both state that he has " moderate pain/less that daily. " Medication Administration Review (MAR) shows that the resident requests Vicodin periodically for headache. There is not care plan that addresses the pain or the use of the medication.	F 280		

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11. R11 is a 29 year old resident who was admitted to the facility on 5/19/08 with diagnoses including bipolar disorder, eating disorder and attention deficit hyperactivity disorder. On review of the most recent resident assessment instrument (Minimum Data Set) dated 6/9/08, facility staff failed to address nutritional concerns, as it relates to the resident's eating disorder. Facility staff also failed to implement a plan of care to address the residents eating disorder. This resulted in the facility's failure to implement nutritional approaches addressing the resident identified eating disorder.

During an interview on 10/30/08, R11 stated that she has never been invited to participate in a care plan meeting. R11 stated that facility staff has never approached her to discuss her eating disorder. The facility failed to implement a plan of care addressing the resident's eating disorder; and failed to ensure that R11 is provided with an opportunity to participate in her care plan meetings.

12. R20 was admitted to the facility on 1/31/08 with diagnoses including schizoaffective disorder, psychosis, asthma, hypertension diabetes mellitus and seizure disorder. On review of the clinical record, it was documented in the Nurse's Notes that R20 has aggressive and threatening behaviors. Facility staff also documented that R20 has been verbally and physically abuse to staff. In addition, facility staff identified that R20 is non-compliant with treatment. R20 was also identified to have a long history of substance abuse.

On review of the clinical record, there were several Nurse's Notes documenting that R20 was

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F 280	Continued From page 45 out of the facility on pass. There was documentation to support that R20 is non-compliant with pass privileges, as he does not return to the facility when expected. On 6/10/08, 9/18/08 and 10/21/08, facility staff filed a missing person's report, as R20 did not return to the facility from his pass. On review of the clinical record, there was no care plan addressing the resident's pass privileges. The facility had not implemented a plan of care to include conditions for continued pass privileges. Facility staff failed to implement a plan of care for a resident with community pass privileges. 13. Care plans have not been updated for R3, R8, R9 or R22.	F 280		
F 281 SS=D	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, record review and interviews, facility staff failed to provide care in a manner that is consistent with professional standards of quality, by failing to follow physician orders, for 3 of 30 sampled resident (R20, R21 and R23). Findings include: 1. R20 was admitted to the facility on 1/31/08 with diagnoses including schizoaffective disorder, psychosis, asthma, hypertension diabetes mellitus and seizure disorder. R20 was observed	F 281		1/11/09

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to have a deformity to the left foot. The resident was missing most of the left heel. During an interview on 10/29/08, R20 stated that he sustained a foot injury while serving in the military. R20 stated that he has a gait disturbance as a result of the injury. R20 further stated that he had a cane when he was admitted to the facility, but facility staff took the cane from him.

During an interview on 10/29/08, E18 (Nurse) confirmed that R20 did not have a cane. According to E18, R20 attempted to hit staff with his cane and his cane was taken from him. According to E18, the resident never had an order for a cane.

On review of the most recent Physician's Order Sheet dated 9/30/08, R20 had a physician's order that stated he, "may have cane for ambulation." R20 also had a physician's order for a left ankle splint. During observations on 10/27/08 to 10/29/08, R20 was no observed to have a walking cane or a splint. Facility staff failed to follow the physician's orders.

2. During clinical record review of R23 on 10/30/08, the POS (Physician's Orders Sheet) dated 10/23/08 on the Medication column, Lisinopril medication was noted with dosage transcription error. Physician's order was 20 mg and the nurse transcribed the dosage orders as 200mg.
E2 (Director of Nursing) has no comment regarding the dosage transcription error, during interview on 10/30/08.
The pharmacy sent the right dosage according to physician's orders, Lisinopril 20 mg.
3. Review of R21's medication administration

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F 281	Continued From page 47 record shows that he has received Vicodin 5/500mg for pain. R21 also has an order for Tylenol 650mg every 4 hours for pain. There is no documentation that shows the Tylenol was offered for pain first before the narcotic was given. There is no assessment of the level of pain documented. R21 has a history of substance abuse and received a total of 36 doses of Vicodin between June and August, 2008. Review of R21's physician order sheets showed that on 8/5/08 and again on 10/9/08, orders were given for the resident to see a Podiatrist and a Dentist. Documentation does not show that these orders were carried out, and R21 stated upon interview on 10/29/08 that he had not been to any appointments. R21 showed the surveyor that he has a very loose molar that needs attention. E2 stated on 10/30/08 that the resident had been refusing to go to appointments, but could not produce documentation to substantiate this.	F 281		
F 323 SS=J	483.25(h) ACCIDENTS AND SUPERVISION The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility:	F 323		2/6/09

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1. Failed to adequately supervise a resident who verbalized desire to commit suicide.

2. Failed to actually supervise residents when it was determined that 1:1 supervision was indicated.

3. Failed to follow policy for supervision when a resident voices the desire to harm self.

These failures resulted in an Immediate Jeopardy.

E1 (Administrator) and E2 (Director of Nurses) were informed of the Immediate Jeopardy on 10/30/08.

The Immediate Jeopardy was determined to have begun on 10/07/08 when R28 informed staff he wanted to kill himself and adequate preventive measures were not implemented.

The Immediacy was removed on 11/02/08 however the facility remains out of compliance at a severity level 2.

The facility also failed to remain free of accident hazards, provide adequate supervision while smoking, provide adequate supervision while eating, provide supervision for residents who are not allowed out of facility, failed to provide adequate supervision of residents to prevent injuries by other residents, and failed to assure 1:1 supervision is completed.

Findings Include:

1. R28's diagnoses include schizoaffective

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F 323	Continued From page 49 disorder. R28 has a history of suicidal ideations with attempts at self harm. Record shows the most recent attempt at self harm was 09/25/08 when R28 cut his right arm with a razor blade and stated he did not want to live anymore. R28 was hospitalized at that time. Nurses notes dated 10/07/08 at 11:30p.m. state "R28 tearful, indicated to staff that he wanted to kill himself. Refused medication, stating it doesn't work. R28 able to be re-directed." On 10/08/08 at 1a.m. notes stated a call was received from a local hospital stating that R28 had called them wanting to be picked up. Notes indicate that R28 was put on 15 minute checks at this time. Note at 2:15a.m. states found R28 lying in tub in supine position with shoestring around neck tied to water faucet. R28 stated "I told you I'm going to kill myself'." Vital signs taken and stable, no injury to neck. Note at 2:30a.m. states Assistant Director of Nurses (ADON) and Psychiatric Rehab Services Coordinator (PRSC) called to advise of situation. Physician was also paged. Note at 2:45a.m. states physician ordered R28 to emergency room for psychiatric evaluation. At 3:45a.m. R28 was transported to the hospital, and emergency contact was notified. Facility policy for Suicidal Behavior states: "All suicidal ideations and/or behaviors are considered to be potentially dangerous. In instances of suicide threats there must be an assessment of the situation, the danger the	F 323		

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situation presents to the resident, its immediacy, and the probability of its being carried out."

Policy also states that a staff member hearing or observing a verbal threat, comment, gesture, or hallucination must stay with the resident and respond as appropriate to the situation. "Under no circumstances leave the resident alone."

Policy states when the issue is a verbal threat, employee must notify the resident's PRSC, the Director of Resident Services (RSD), and the Director of Nursing (DON) or designees (supervisors designated to be on call.) The Director of Resident services or the Director of Nursing or designee must assess the potential dangers of the incident and contact the resident's physician or psychiatrist with recommendations.

Policy states the Charge Nurse is to complete an Accident/Incident Report following all appropriate procedures.

E2 (DON) was interviewed on 10/30/08 and stated she was never made aware of this situation involving R28 on 10/07/08.

There is no evidence staff followed policy for Suicidal Behavior by conducting any assessment when R28 made a verbal threat of suicide on 10/07/08 at 11:30p.m.

There is no evidence staff stayed with R28 to assure that he did not act on the threat.

There is no evidence staff followed policy of notifying PRSC, RSD, or DON of the situation for further direction.

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F 323	Continued From page 51 There is no evidence an Accident/Incident Report was completed. 2. Nurses notes of 10/19/08 at 7p.m. state R28 crying uncontrollably for long periods of time stating "nobody loves me and I have no friends." R28 placed on 1:1 observation for depression symptoms and possible danger to self. At 10p.m. notes indicate R28 continues on 1:1 observation and states he does not feel better. R28 requested something for his nerves. Physician was called, but there is no indication of any response. From all records presented to surveyor, it is unclear as to all the events and times of incidents regarding R28 the evening of 10/19/08 through to the morning of 10/20/08. As previously stated, R28 was put on 1:1 observation at 7p.m. 10/19/08, but 1:1 observation sheets were not started until 7:45p.m. Record indicate that at approximately 11:30p.m. 1:1's were being done in the day room of seventh floor. At 11:30p.m. a Code Yellow (behavioral emergency) was called because R28 was fighting with staff and trying to hit staff, refusing to stay on 1:1, and wanting to go to his room. R28 was successful in getting back to his room. Code was called by E33 (Nurse Aide). E36 (Staff Nurse) was on another unit at time Code Yellow called.	F 323		

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Two security guards responded (E34 & E35). Written statement from E33, E34, and E35 state R28 was refusing to get up from bed and clinging to bed frame. R28's mattress was subsequently flipped and R28 was dragged out of room by E34 and E35. Somehow R28's pants fell to either his knees or ankles, and R28 was dragged part way down hallway by E34 and E35.

E35's statement indicates that it was E33's idea to flip R28's mattress. Once in hallway R28 again grabbed E35's leg trying to bite him. E35 put his hand between R28's mouth and his leg and finally got R28 off his leg. R28 was carried partially down hall with E35 having R28's top, E34 had the legs, and R28's behind was on the ground. R28 subsequently walked part of hall to day room.

At time of incident E35 had not been trained in Crisis Prevention Interventions (CPI) and should not have put his hand on a resident.

E34's statement indicates that R28 would not get out of bed. R28's arms had to be pulled off bed by E33, E34, and E35. R28's mattress was flipped, and R28 ended on the floor. E34 grabbed his legs and E35 grabbed his arms and we pulled/dragged R28 out of the room. In the hall R28 had a hold on E35 legs. They finally got R28 off E35's leg. E34 was asked how R28's pants got down, and E34 stated R28 had loose jogging pants on.

E33's statement of 10/21/08 indicates when she came to work for night shift at 11p.m. on 10/19/08 1:1 was endorsed to her. E36 (Staff Nurse) made decision to have mattresses pulled into day room for the 1:1 observation. E33 asked R28 if

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he was aware he was on a 1:1, and R28 said yes.

R28 refuses to go to day room and started hollering. E33 called E36 and asked other Nurse Aide (E30) to watch R28 because he could not be left. E33 called the code yellow at 11:30p.m. Security had a hard time getting R28 out of bed. They had to physically move him out of the bed. R28 was saying "they are hurting me." It took about 30 minutes, E36 came to floor and R28 went to the day room. During Code R28 was kicking, scratching, and biting.

E33's statement of 10/23/08 indicates she told R28 the nurse wanted him to go to the dayroom, and he would not go. Another Nurse aide was asked to tell the Nurse. E30 (Nurse Aide) called the Code Yellow.

Further statements indicate someone else notified security. Security guards responded. R28 was holding on to bed. Security was trying to get him off bed. Somehow R28 rolled off bed. He was trying to kick and bite. R28 was dragged out of room. R28 was holding onto the wall. E33 said "you may have to stop." By that time R28's clothes were off.

E36 (Nurse) came and talked to R28. R28 then got up and walked to dayroom. E33 then brought R28's mattress to day room.

During this interview E33 was asked if she felt security was rough with R28, why she did not report it. E33 then stated "maybe they were not rough." E33 was asked how security was dragging R28. E33 stated "one had him by the arms and one had him by the legs." E33 was

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asked if that was acceptable. E33 stated '"No, I do not."

E33 was asked if R28 said anything after the ordeal was over. E33 stated R28 asked for popcorn and said look what security did to me. E30 called the nurse who did not come right away until someone said he would tell Administrator. Nurse looked at R28 and said 'it doesn't look like a a new bruise.'

Nurse note (E36) dated 10/20/08 at 1:40a.m. states 'R28 showed writer right forearm inner area with reddish mark.. R28 stated security hurt me. No complaints of pain, area cleansed with normal saline, on 1:1 in day room. No further body checks were documented done by E36.

E33 did not report rough handling nor dragging a resident down hallway as suspected abuse.

E36 did not report R28's allegation that security hurt him.

Incident Report faxed to the Department on 10/20/08 states R28 attempted self harm by wrapping shoe string around neck while lying down. Slight abrasion noted on neck, no other injuries. R28 was petitioned for psychiatric admission, remained safe prior to transport.

On 10/30/08 E2 was interviewed regarding R28 being found with a shoe string around his neck, and nothing about this was addressed in nurses notes.

During interview E2 stated that R28 was on 1:1 on 10/20/08 and endorsement of 1:1 was not carried over from the night shift to the day shift.

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F 323	Continued From page 55 At 7a.m. R28 was again found with a string around his neck. During interview it was discussed that this was not documented in the record. E2 confirmed that R28 should have been supervised on a 1:1 basis, and all information should have been documented in R28's record. Special Observation Documentation Sheets for R28 for 10/19/08 and 10/20/08 indicated no observation of 1:1 documentation after 6a.m. until 7a.m. on 10/20/08. Statement made by E29 (Nurse Aide) on 10/20/08 indicated she want to the day room on 10/2008 at approximately 7a.m. and saw E30 and E33 sitting at a table near R28, who was lying on a mattress. R45 was sitting at a table. E29 asked R28 how he was doing and R28 responded 'not good.' At this point E29 noticed that R28 had a shoe string tied around his neck. E29 removed the shoelace and called nurse. It is not clear how R28 was able to tie a shoe string around his neck when he was apparently being monitored on a 1:1 basis. On 10/20/08 at 10:30a.m. E38 took a statement form R28 regarding events of 10/20/08. This statement indicated that R28 did become physically aggressive with staff and was restrained by staff. R28 received bruises on right arm. R28's mattress was brought into the day room for the night. At 6a.m. R28 stated he tied a shoe lace around his neck to attempt suicide. The Nurse aide was 20 feet away reading the paper and sleeping. The 7a.m. Nurse Aide found him with the shoe lace around neck.	F 323		

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The Facility took the following actions to remove the Immediate Jeopardy:

The Facility is in-servicing all active clinical staff on the procedure for managing residents who present with suicidal ideations. The training will include the following components:

-Placing residents on 1:1 for safety when any suicidal behavior is expressed. During 1:1 checks, staff must be within an arms length of the resident al all times. (See attachment #1, 1st point)
-Review of what to do if a resident becomes suicidal (attachment #1)
-the clinical supervisor on call and the resident's psychiatrist will be notified as soon as practical one the resident's immediate safety has been established.
-Resident will be placed on behavior follow-up and 24-hour report to ensure that staff communicate from shift to shift.
-Residents on 1:1 checks will be monitored until such time that the clinical manager, in consultation with the psychiatrist, determines that the resident no longer required 1:1 monitoring.
In-services were completed 11/02/2008.

The facility will identify all residents currently in need of special monitoring including hourly, 30 minute checks, 15 minute checks and 1:1 monitoring. Each resident identified will be assessed by licensed personnel. This assessment will be reviewed with the resident's psychiatrist. The Quality Assurance Sheet (attachment #2) will be used to monitor compliance with the policy.
This will be completed by 8p.m. on 10/30/2008.

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The facility identified all resident in the facility with suicidal ideations, sundial attempts, and/or self harm. 135 resident were identified. All care plans were updated on 10/31/08. Resident specific problems were identified and approaches were developed.

The facility will monitor by the use of an observational check Quality Assurance Sheet to be completed for every resident on observation on a daily basis. This will be reviewed by the Director of Nurses, or clinical manager daily. Any deficiencies identified will be corrected as soon as practical. This may include staff training and progressive discipline if needed. The data will be complied, summarized and reviewed by the DON and/or PRSC on a daily basis.
This will begin on 10/31/2008.

3. Nurses notes on 10/19/08 at 6:30p.m. state that R45 was found in the men's bathroom adjacent to the stall where a paper towel had been set on fire. R45 denied setting the fire. R45 was found with matches but continues to deny that he set the fire. R45 was placed on 1:1 observation until further notice.
Facility obtained statement by E30 on 10/20/08 indicates that E30 started work at 11p.m. on 10/19/08. He was told that R28 and R45 were on 1:1's. R28 was seen walking down down hallway with a Nurse Aide. E30 stated he went to R45's room and R45 was asleep and no one was with him, so he stayed to do the 1:1 for R45.
Statement made on 10/20/08 by E31 (Nurse Aide) indicates she arrived at 7a.m. on 10/20/08. She was asked to go downstairs to get a breakfast tray for another resident and stated she saw R45 in breakfast line in main dining room. Staff were not with R45. When she returned to

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the seventh floor she was informed that R45 is on a 1:1. R45 returned to unit at 8a.m.
4. R1 on 10-28-08 in resident room there were items that were resting on top of the radiator.

5. On 11/3/08 at 10:40 a.m. it was observed in the Smoking Room on the 1st floor, there were 24 residents present. Residents were observed smoking, rolling their own cigarette and having resident outbursts. There were no staff present in room monitoring these residents. Surveyor spoke with staff outside the room, who were out of view of the residents. Staff stated they should be in the room however could not because of other duties such as passing out cigarettes and other staff on breaks. E1 (Administrator) was informed of the situation by Surveyor.

6. Breakfast meal on 10-28-08 there were residents in the Dining Room eating with their fingers, wearing torn clothing, buttering toast with a spoon. No supervision by staff. Staff not present taking nutritional intakes of residents.

7. R27 has a diagnosis of Schizophrenia. On 10-21-08, R27 got into a physical altercation and was put on restrictions that she is not allowed out of the building. On 10-28-08 according to the nurses notes, R27 left the facility without signing out 1:00 p.m. Interview with staff and E14 (Food Service Supervisor) the facility did not see R27 go out of the building, however a staff member was at a store near the facility and observed R27 walking on the street. Staff called to R27 however R27 took off running. Note reflects that R27 returned back to facility at 8:00 p.m. Interview with R27 on 10-30-08 at 10:50 a.m. in the Dining Room stated that he was aware that R27 got out of the facility because the facility

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notified all staff. The facility is monitored at the front door by 2 security guards however R27 still walked out. According to E23 (Corporate Nurse) this incident was not reported to the Illinois Department Department of Public because R27 was not missing for 24 hours. Interview with R27 stated that she had left the facility and went to the Zoo.

8. R38 has a diagnosis of Schizophrenia. According to the incident report date 9/10/08 reflects that resident was out of the facility since undetermined time. R38 was suppose to be on the patio at 8:30 a.m. A male peer reports that the resident left at 11:00 a.m. assisted by him. Resident has not returned back to facility. R38 was on restriction to stay at the facility. Facility did not know how resident left the premises.

9. R39 has a diagnosis of Schizophrenia. On 9-5-08 a code red was called at the facility and the building was evacuated. R39 was later reported missing. There was no supervision when the building was evacuated. R39 was on restriction to stay on the premises of the facility.

10. R4 was admitted to the facility on 9/29/08 with a diagnosis including Schizoaffective Disorder. R4 was observed on 10/27; 10/28 and 10/29/2008 throughout the facility at varies times.
10/5/08-10;05am-"..physically verbally aggressive to staff and peers...approached another peer on the 4th floor....staff redirected resident off floor since she is restricted from 4th. fl. ...aggressive with staff and a code yellow was called.. Resident came back to the fourth floor 20 mins. to spit in peer face and left."

10/5/08-12p-" noted resident yelling, swearing,

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threatening to have him killed...Aggressive to all staff and peers...took resident to patio to vent and talk...resident calmed down came back into facility and went to 8th. floor and became aggressive with peer..."

10/12/08-7:50pm- res. involved in physical altercation with male peer....res. had a scratch on face however refusal treatment."

10/20/08-4:25am- Code yellow called in smoke room after resident was knocked to the ground by a male peer..."

The facility fails to ensure adequate supervision is maintained in that R4 is able to visit floors that resident is restricted from, and subsequently receives injuries from peers.

11. R32 was admitted to facility on 10/20/08 at 3pm. The nurses notes at 8pm the same day denotes," transferred to room 704 as roommate threatened to kill resident."
Nurses notes cont'd:
10/20/08- 8:20pm," asked roommate about the problem..and why he wants to kill roommate,.. said resident destroyed his electrical cord."
10/21/08-6pm-" resident observed to be out of the floor, but noted to be on the third floor. unable to be redirected to floor.. resident is to be transferred to the 6 th. floor...".
10/28/08-8:45" Code yellow called on 5th. floor...res. was reportedly grabbing 5th. floor residents in snack line and was unable to be redirected by staff back to his floor."
10/29/08- 8:50am- "..resident walked over to a peers room and started touching everything..when being directed by staff became physically aggressive toward staff...resident

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petitioned to the hospital."
12. Review of Facility Incident report dated 11/2/08 at 7:15 PM, a resident to resident physical altercation between R33 (4th floor resident) and R34 (6th floor resident) occurred in the 1st floor smoking room.

According to the facility follow up of the incident report :

R34 recounted that " a male peer had slapped him on his butt, that this event had caused him to have flashbacks of an earlier incident in jail and he just snapped. "
That a PRSC (Psychosocial Rehabilitation Coordinator) had gathered the altercation information between R33 and R34, from a " Code yellow Team ".
This incident report indicated that the incident was an unwitnessed incident.

R33 was observed on 11/3/08 at approximately 10:00AM, with thick, bulky dressing, intact over his L (left) hand up to his wrist.

Interview of R33 on 11/3/08, stated that he was in the 1st floor smoking room yesterday at 6:30 PM - 7:00 PM, when R34 pushed him, and he also in turn pushed him back and then he (R33) was hit with a chair.
R33 then told surveyor that he was sent out to the hospital E.R. (Emergency Room), wherein his L) hand was x-rayed and also sutured. According to R33, he had sustained fracture and lacerations on his L) hand.
R33 indicated during this interview that there was no staff in the smoking room.

R34 according to incident report sustained

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F 323	Continued From page 62 scratch marks on his L) side of his neck, 2 mm by 2 mm. R34 was transferred out of the facility due to the incident. Chart review of R33 showed a total of 14 sutures for the lacerations sustained in his L hand, from a resident to resident altercation on 11/2/08.	F 323		
F 325 SS=E	483.25(i) NUTRITION Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on record review and interviews the facility failed to assess resents nutritional needs in a timely manner for 6 of 30 sampled residents (R1, 6, 7, 21, 26 & 27). Examples include: Interview with E14 revealed that the Dietitian charts on the residents quarterly. 1) R1 has a diagnosis of Paranoid Type and Schizophrenia. Diet is No Concentrated Sweets. The last Nutritional Assessment was done on 8/9/08. Height 63" with an ideal body weight of	F 325		1/11/09

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F 325	Continued From page 63 115 plus or minus 10%. Weights 5/08 183 lbs, 8/8/08 160 lbs and 9/08 was 163 lbs. No current weight. Weights fluctuate and there is no follow up for high weights. Also no follow up on a 20 lbs. weight loss in 4 months. 2) R6 has a diagnosis of Obesity, High Cholesterol, Hypertension, GERD and Schizophrenia. Diet includes: No Concentrated Sweets, No Added Salt Sandwich at H.S. Height 61", ideal body weight of 105 plus or minus 10%. Weights 8/08 203.25 lbs. and 10/08 is 209 lbs. The note from 8/9/08 addresses abnormal labs from 7/3/08. Labs from 8/27/08 not addressed yet where Hemoglobin was low at 11.8 and MCV at 76.0 low. There has been a weight gain that has not been addressed yet of 5.75 lbs. 3) R7 has a diagnosis of Bi Polar, GERD and Chronic Constipation. Diet includes No Added Salt and No Concentrated Sweet. Height 68" and ideal body weight of 154 plus or minus 10%. October weight was 198 lbs. The last nutritional note was from 8/7/08 addresses abnormal labs from 5/7/08. High weight not addressed. Labs not addressed from the following dates: 7/30/08 WBC 10.9 high 8/8/08 Triglyceride high at 477 and LDL Cholesterol low at 28. 8/27/08 WBC 11.3 high 9/24/08 RBC 4.46 low and Hematocrit 40.9 low. 4) R27 has a diagnosis of Schizophrenia, Hypertension and Hepatis C. Diet includes No Added Salt and No Concentrated Sweets. Height	F 325		

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F 325	Continued From page 64 5'0 with an ideal body weight of 110 lbs. 9/08 weight is 210 lbs. There has been a constant weight gain and there has been no intervention by the R.D. Weights 2/08 194.5 lbs, 5/08 199 lbs. and 9/08 of 210 lbs. 5) R26 has a diagnosis of Obesity, Diabetes and Schizoid Affective Disorder. R26 takes Insulin. No Concentrated Sweets and No Added Salt. Height 65 inches ideal body weight of 125 pounds plus or minus 10%. Oct weight 233 lbs. Nutritional notes were from 5/21, 8/5 and 10/14/08. The weight was at 272 lbs 6/08. There had been a 39 lbs. weight loss in 4 moths. There was no constant follow up for such a large weight loss. 6) R21's weight record shows on 7/3/08 he weighed 192lbs and then on 9/08 he weighed 176lbs. This would mean a 16lb weight loss in 2 months. The resident eats a regular diet with no documentation that he has a problem with intake of food. No reweigh of the resident was documented. Interview with E26 (Dietary Technician) on 10/29 at 2:15pm revealed that she did not know where the 192lb weight came from but it was used for assessment purposes. It also should have been in the significant weight loss report for July, but it was not. There was no diet changes made, so it " must not have been a problem. " E26 could not give a reason for this discrepancy in weight, why the resident was not reweighed, or if any follow-up was done. Also see F363 for menus not prepared for each diet.	F 325		

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F 333 SS=D	483.25(m)(2) MEDICATION ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to administer medication as prescribed and failed to administer medication in dose ordered by physician for 2 of 30 sampled residents (R25 and R30). Findings include: 1. R25 is a 46 year old resident who was admitted on Oct.22, 2008 with a diagnosis of schizoaffective disorder. Record review showed that an order was written on the Physician Order Sheet for the medication Risperdal to be given daily to R25. Review of the Medication Administration Record, however, did not show that R25 had received the Risperdal since ordered on Oct.22, 2008. When interviewed, E4-LPN (Licensed Practical Nurse) stated that she thought the ordered Risperdal was written as a PRN (as needed) and not on a scheduled basis. R25 had missed the medication for eight straight days and still would not have received the medication if not prompted. 2. On 10/29/08 at approximately 1:00p.m. R30 was observed in the third floor nursing unit during a behavioral emergency. It was determined by staff present that R30 required medication for behavior. Prior to administration, E27 (Staff Nurse), was asked what medication was being administered to R30. E27 stated medication was Thorazine 2	F 333		1/11/09

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F 333	Continued From page 66 mls. After R30 was medicated and aggressive behaviors stopped surveyor requested to see actual medication vial. E27 stated that entire ampule of Thorazine was administered to R30. Ampule contents listed as 2mls. of Thorazine at 25mg per ml. E27 confirmed R30 was given 50mls. of Thorazine. Physician order for Thorazine states 'inject 1ml. 25mg. intramuscularly every 4 hours as needed for anxiety/agitation.'	F 333		
F 353 SS=G	483.30(a) NURSING SERVICES - SUFFICIENT STAFF The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced	F 353		1/11/09

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by:
Based on record review and interview the facility failed to assure that sufficient staff are available on the night shift to provide necessary care to meet resident needs.

Findings Include:

Facility is Licensed for 450 beds. At time of survey census was 415 residents, approximately 70 residents on each of facility's six units.
Review of usual staffing patterns for the month of October 2008 shows that on the night shift three licensed nurses are scheduled and each covers two units. Two nurse aides are scheduled on each of facility's six units.
For the night shift of 10/19/08 to 10/20/08 E36 was the licensed nurse scheduled to cover the fourth and seventh floors. E30 and E33 were the nurse aides scheduled to work on the seventh floor.

On the evening shift on 10/19/08 two seventh floor residents (R28 & R45) had been put on 1:1 observations. Nurses notes of 10/19/08 at 7p.m. state R28 crying uncontrollably for long periods of time stating 'nobody loves me and I have no friends' R28 placed on 1:1 observation for depression symptoms and possible danger to self. R28's most recent attempt at self-harm was 10/07/08 when found with a shoe lace tied around neck and to the faucet in a bathtub.
Nurses notes on 10/19/08 at 6:30p.m. state that R45 was found in the men's bathroom adjacent to the stall where a paper towel had been set on fire. R45 denied setting the fire. R45 was found with matches but continues to deny that he set the fire. R45 was placed on 1:1 observation until further notice.

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Record indicate that at approximately 11:30p.m. 1:1's were being done in the day room of seventh floor. At 11:30p.m. a Code Yellow (behavioral emergency) was called because R28 fighting with staff and trying to hit staff, refusing to stay on 1:1 and wanting to go to his room. R28 was successful in getting back to his room. Code was called by E33 (Nurse Aide). E36 (Staff Nurse) was on another unit at time Code Yellow called. Two security guards responded (E34 & E35). Written statement from E33, E34, and E35 state R28 refusing to get up from bed, clinging to bed frame. R28's mattress was subsequently flipped and R28 was dragged out of room by E34 and E35. Somehow R28's pants fell to either his knees or ankles and R28 was dragged part way down hallway by E34 and E35.
On 10/30/08 E2 was interviewed regarding R28 being found with a shoe string around his neck when he was supposed to be monitored on a 1:1 basis and nothing about this was addressed in nurses notes.
During interview E2 stated that R28 was on 1:1 on 10/20/08 and endorsement of 1:1 was not carried over from the night shift to the day shift. At 7a.m. R28 was again found with a string around his neck. During interview it was discussed that this was not documented in the record. E2 confirmed that R28 should have been supervised on a 1:1 basis and all information should have been documented in R28's record.

Special Observation Documentation Sheets for R28 for 10/19/08 and 10/20/08 indicated no observation of 1:1 documentation after 6a.m. until 7a.m. on 10/20/08.

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F 353	Continued From page 69 Facility obtained statement by E30 on 10/20/08 indicating that E30 started work at 11p.m. on 10/19/08. He was told that R28 and R45 were on 1:1's. R28 was seen walking down down hallway with a Nurse Aide. E30 stated he went to R45's room and R45 was asleep and no one was with him, so he stayed to do the 1:1 for R45. Statement made on 10/20/08 by E31 (Nurse Aide) indicates she arrived at 7a.m. on 10/20/08. She was asked to go downstairs to get a breakfast tray for another resident and stated she saw R45 in breakfast line in main dining room. Staff were not with R45. When she returned to the seventh floor she was informed that R45 is on a 1:1. R45 returned to unit at 8a.m. It is the policy of the facility that an check of a resident's whereabouts is completed hourly. It is also the policy of the facility that 1:1 observation is continuous observation of a resident by staff no more than an arm's length away from the resident. On a unit of approximately 70 residents with mental illness, with two residents being on 1:1 observations, two nurse aides scheduled to the unit along with a nurse who covers two units it is determined the facility does not have sufficient staff to meet resident needs.	F 353		
F 356 SS=C	483.30(e) NURSE STAFFING The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:	F 356		1/11/09

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- Registered nurses.
- Licensed practical nurses or licensed vocational nurses (as defined under State law).
- Certified nurse aides.

o Resident census.

The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:
o Clear and readable format.
o In a prominent place readily accessible to residents and visitors.

The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.

The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.

This REQUIREMENT is not met as evidenced by:
Based on observation and interview the facility failed to publicly post statutorily mandated staffing data regarding the number of licensed and unlicensed nursing staff directly responsible for resident care on each daily shift.

Findings include:

On 10/27/08 to 10/30/08, during the Annual Certification survey conducted at this facility, information regarding the number of licensed and unlicensed nursing staff per shift was not posted in the facility.

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F 356	Continued From page 71 When interviewed regarding required posting of staffing, E1 (Administrator) stated the staffing is posted in the first floor lobby. Posting was not observed by surveyors any days of the survey.	F 356		
F 360 SS=F	483.35 DIETARY SERVICES The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets the daily nutritional and special dietary needs of each resident. This REQUIREMENT is not met as evidenced by: Based on interviews, menu review and direct observations the facility failed to provide each resident with a nourishing, palatable, well-balanced diet that meets the daily nutritional and special dietary needs of each resident Findings include: See the following tag numbers: 1) F361- Dietitian Hours do not served meet the nutritional needs of all residents. 2) F362- Staff are not trained in the Kitchen for portions sizes, substitutes and or sanitation. 3) F363-Menus are not always written out for each diet, only General Diets. Menus not always written out clearly. 4) F363- Foods not always served attractively. 5) F366-Substitutes not always for refusal of regular food.	F 360		1/11/09

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F 360	Continued From page 72 6) F367-Special diets not always served correctly. 7) F369-Bedtime snacks not always served nor a variety. 8) 371-Sanitation in the Kitchen. 9) F325-Nutritional Assessments	F 360		
F 361 SS=F	483.35(a) DIETARY SERVICES - STAFFING The facility must employ a qualified dietitian either full-time, part-time, or on a consultant basis. If a qualified dietitian is not employed full-time, the facility must designate a person to serve as the director of food service who receives frequently scheduled consultation from a qualified dietitian. A qualified dietitian is one who is qualified based upon either registration by the Commission on Dietetic Registration of the American Dietetic Association, or on the basis of education, training, or experience in identification of dietary needs, planning, and implementation of dietary programs. This REQUIREMENT is not met as evidenced by: Based on review of nutritional assessments, menu review, meal observations, direct observations, group and individual interviews, the facility failed to employ a Dietitian full time to meet the nutritional needs of 413 residents in the facility. See the following tags:	F 361		1/11/09

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F 361	Continued From page 73 1) F362-Staff not trained in the Kitchen for portion sizes, substitutes or sanitation. 2) F363-Menus not always written out for each diet, nor written out clearly. 3) F364-Foods not always served at appropriate sizes. 4)-F366-Substitutes not always offered. 5) F367-Special diets not always served correctly. 6) F369-Bed time snacks not always served nor variety provided. 7) F371-Sanitation issues throughout the Kitchen. 8) F325-Nutritional Assessments not always accurate.	F 361		
F 362 SS=F	483.35(b) DIETARY SERVICES - SUFFICIENT STAFF The facility must employ sufficient support personnel competent to carry out the functions of the dietary service. This REQUIREMENT is not met as evidenced by: Based on direct observations, interviews and menu review, the facility failed to provide inservices or training to all staff in the Kitchen as evidenced by the following:	F 362		1/11/09

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F 362	Continued From page 74 The facility does have staff in the Kitchen however these members have had only 2 inservices since 2004. 1st inservice was on Sanitation in the Kitchen dated 2004 and the next inservice was about checking personnel bags at the front of the facility date September 2008. See the following tags: 1) F363-Menus not always followed. 2) F364-Foods served attractively. 3) F366-Substitutes not offered. 4) F367-Special diets not served correctly. 5) F369-Snacks not always given. 6) F371- Sanitation in the Kitchen..	F 362		
F 363 SS=F	483.35(c) MENUS AND NUTRITIONAL ADEQUACY Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. This REQUIREMENT is not met as evidenced by: Based on menu review, meal observations and interviews, the facility failed to provide a menu for each diet served at the facility. Examples include. The facility only has a 3 week menu cycle for	F 363		1/11/09

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F 363	Continued From page 75 General diets, the facility a census of 413 residents. Menus are not always written out for each diet including 1) No Added Salt 2) No Concentrated Sweets 3) Low Fat/Low Cholesterol The General 3 week menu cycle is not always written out clearly for food items to be served. Examples include: Week 3 Luncheon Meal- Wednesday (M & Cheese) Week 3 Luncheon Meal-Friday(Chicken Thigh Sand) Week 3 Luncheon Meal -Monday (Mash & gray) Week 1 Luncheon Meal-Friday (Beef San on Bun)	F 363		
F 364 SS=F	483.35(d)(1)-(2) FOOD Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on direct observations, group interviews, individual interviews and food temperatures, the	F 364		1/11/09

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F 364	Continued From page 76	F 364		

facility failed to: served food attractively, serve proper portion size and offer condiments which could enhance the flavor of the food. Examples

1) On 10/27/08 at 10:04 a.m. it was observed that the Chili Mac (3 pans) were observed sitting in the steam table. According to the Cook, Lunch was to be served from 11:30 a.m to 1:00 p.m.

2) On 10/27/08 Luncheon Meal, the posted menu reflects:

Chili Mac (6 oz).
House Salad (1 cup)
CornBread

Interview with E14 (Food Service Supervisor) when asked the amount of meals served at lunch, or the amount of residents, E14 could not come up with a census. He stated that he cooks for the employees and residents. Interview with the Cook, she claims she always has enough food for everyone. According to the Cook she cooks for approximately 426 or 4 1/2 pans. She used 50 lbs of ground meat, 20 lbs of pasta, and 6 #10 cans of kidney beans and 4 onions. The recipe given to Surveyor for 400 portions, calls for 65 lbs of ground meat, 3 lbs of onions, 57 lbs of Kidney Beans. Tomatoes, tomato juice, salt and pepper not used.

Appropriate servings were not served.

Mac and Chili (4 oz).(dried out)
Lettuce, plain (1/4 cup) (no other vegetables)
White Bread placed directly on top of the Mac and Chili. Cornbread not served.

The Lemonade had an after taste. When asked

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F 364	Continued From page 77 what type it was the server stated diet lemonade, everyone can have it. At 11:20 a.m. the evening Cook when questioned stated that she was baking off the chicken for the evening meal. The evening meal starts at 4:00 p.m. The refrigerator had bowls or egg salad and tuna salad that had a piece of wax paper on top of it. When the cover was removed, it was dried up. Breakfast Meal: On 10/28/08 at 6:40 a.m. at the steam table the toast was stacked high in pans not covered. The toast was hard and cold to touch. Throughout the meal service on 10-27-08 Lunch and 10-28-08 Breakfast and Luncheon meals, salt or pepper packets were not offered to the residents.	F 364		
F 366 SS=F	483.35(d)(4) FOOD Each resident receives and the facility provides substitutes offered of similar nutritive value to residents who refuse food served. This REQUIREMENT is not met as evidenced by: Based on direct observations, interviews and menu review, the facility failed to offer substitutes of equal or similar nutritive value for food served. Examples include: There was many complaints revealed through individual interviews and group interview, that residents do not have any input into menu and	F 366		1/11/09

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F 366	Continued From page 78 that they are tired or tuna, cottage cheese, cheese sandwich and egg salad as a substitute. These substitutes were observed to be dried out. Residents complain at all the meals they have to wait until all staff and residents eat if they want seconds. Usually there they run out of the posted food item and they are offered substitutes. Interviews reveal that hot foods are not served hot. Portions are usually small. Residents are upset that employees eat before them at each meal. Luncheon Menu 10-27-08 1) If residents refused the lettuce they were not offered a substitute, including (R40, R41, R42). Breakfast meal 10-28-08 1) If residents refused the egg omelet nothing was offered in its place, including (R41). Luncheon meal 10-28-08 1) If the resident refused sauerkraut no substitute was offered.	F 366		
F 367 SS=F	483.35(e) THERAPEUTIC DIETS Therapeutic diets must be prescribed by the attending physician. This REQUIREMENT is not met as evidenced by: Based on direct observations, interviews, menu review, group interview the facility failed to serve therapeutic diets as ordered, for 3 of 3 meals observed. Findings include:	F 367		1/11/09

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F 367	Continued From page 79	F 367		

Continued From page 79

1) All 3 meals observed the facility doesn't have diet orders or a diet cardex to check appropriate diet if diet card was lost. Interview with E14 (Food Service Supervisor) states he doesn't have a cardex or diet orders, the only thing he has is the tray cards. Surveyor observed numerous residents without tray cards because they were lost. No attempt to obtain a diet order, resident was presented with a general diet.

2) Interview with E14 revealed that the diet patterns are written on the tray cards, however when observed many of the patterns were left off.

3) The facility has a 3 week menu cycle in which is General, no breakdown for other diets available.

4) The facility doesn't have a diet manual, only procedures for the Kitchen.

5) The facility has a census of 414, the diets that are suppose to be offered are No Concentrated Sweets, No Added Salt, General and Low Fat and Low Cholesterol. All diets receive the same foods which are high in sodium, cholesterol and sugar. Examples include:

Polish sausage, hot dogs, sauerkraut, catsup, canned ravioli, pizza, fried chicken, bratwurst, ham, corned beef, lunchmeats and breakfast sausage.

6) Interview with E14 stated that he doesn't have anyone on Low Cholesterol/Low Fat diets, however tray cards were observed where the following residents tray cards do reflect that diet. These residents were observed to be on a Low Cholesterol diet.

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F 367	Continued From page 80	F 367		

Breakfast meal on 10/28/08 the following received egg and cheese omelet and at the Luncheon meal received the bratwurst and canned german potato salad. (R35, R36 and R37).

7) Residents that were to receive a double portion diet as the Luncheon meal on 10-27-08 all received a single portion. Interview with E14 stated that the Double Portion is the same as the Large Portion and the only item that is doubled is the protein.

8) At the luncheon meal on 10-27-08, Chili Mac was suppose to be served at 6 oz. instead it was served at 4 oz. The lettuce salad was suppose to be served at 1 cup instead 1/4 cup of plain lettuce was served. At the Breakfast meal Omelet was to be served at 4 oz. instead it weighed 3 1/2 oz.

9) At all 3 meals 10-27-08 Luncheon, and 10-28-08 Breakfast and Luncheon , the residents who do have tray cards do not present or show the tray card to the servers, residents receive the same food items. At the Breakfast meal on 10-28-08, the residents who eat early received their trays, approximately 40 residents, the facility doesn't use the tray cards. Staff claim they know everyone's diet.

10) At the Breakfast meal on 10-28-08 all No Concentrated Sweet diets received regular jelly instead of sugar free.

11) At the Breakfast meal on 10-28-08 residents who refused omelets were not offered a protein substitute, including R43.

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F 368 SS=D	483.35(f) FREQUENCY OF MEALS Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community. There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below. The facility must offer snacks at bedtime daily. When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served. This REQUIREMENT is not met as evidenced by: Based on interviews and group interviews the facility failed to provide a nourishing snack at bedtime. Examples include: 1) Residents interviews and group interviews revealed that at times they do not receive a bedtime snack. Residents often complain that there is no variety. Also complaints that they serve oyster crackers. In review of the menu cycles, oyster crackers do appear. 2) R14 has current physician orders for general, double portion diet with fruit and sandwich at bedtime. During interview on 10/30/08 R14 stated he does not receive fruit or sandwich at bedtime.	F 368		1/11/09
F 371	483.35(i) SANITARY CONDITIONS	F 371		1/11/09

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F 371 SS=F	Continued From page 82 The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on direct observations, policy review and interviews the facility failed to store, prepare, distribute and serve food under sanitary conditions. Examples include: Tour of Kitchen with E14 (Food Service Supervisor) on 10/27/08 at 9:55 a.m. 1) Stacks of residents food trays were observed cracked on its edges. 2) Dishmachine not in working order. There were 3 men drilling the floor in front of dishmachine. According to E14, the dishmachine had not been working since the Breakfast meal on 10/26/08. E14 stated that the grease trap had broke and it backed up in the dishroom. 3) Behind the tray line in the main dining room it was observed that Styrofoam bowls were being stored in a milk crate. Milk crates are not durable shelving and the milk crate had old stains on its sides. 4) On the base tray of the upright toaster there	F 371		

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was a wrapper from a plastic apron, package of syrup and crumbs on it.

5) The cook was observed cutting up lettuce, this case of lettuce had its leafs were brown and black.

6) There were cracker packs stored in a milk crate.

7) There was a tray on peanut butter and jelly sandwiches stored on a shelf under shelving, according to cook they were stored there for the luncheon meal. Cook stated that they were there since 9:15 a.m. No label or date.

8) In the reach in cooler there were 2 Styrofoam trays of tuna salad that were sitting directly on the floor. No label or date.

9) The walk-in cooler in the Kitchen was observed being worked on by workers. According to E14 the coolers compressor went out a couple of weeks ago.

10) In the Kitchen the bowls on the shelving were greasy. The lids on the flour, sugar and oatmeal bins had food debris on them.

11) The floor in the walk-in was observed to have food particles built up in the corner of edges. The floor itself was dirty. There was a pan of cooked rolls being store in a pan that had drainage holes in it.

12) The stove burners had burnt on food particles and black dried stains.

13) There were 2 ovens that were observed with

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F 371	Continued From page 84 dried on food particles on the sides and bottom base. 14) The floor throughout the entire Kitchen was observed to have stains, missing tiles and the floor grooves have imbedded dirt which makes it not cleanable. 15) The trap which remains open by the steam kettle was observed to have a build up of mold and dry food particles. 16) The large mixer was covered with a plastic bag, when uncovered the bowl and the holder had dried food spills and splatters on it. 17) The walk-in freezer had a build up of rust on the floor. There were 4 milk crates being used for shelving for cases of food. There was 1 bag of mixed vegetables and french fries that were open, no label or date on them. 18) The Fryer in the Kitchen which contained oil, according to E14 had been cleaned a week ago. Under the lid there was dried food particles and dried up french fries on it. 19) The Dry Storage door was being held open with a food can. The drain on the floor was open and had dried up of dirt in it. A container of soup base being stored on top of a milk crate. 20) The ice machine had rust in its inside. The rust was observed on the steel bars and screws. 21 Throughout the meals served on 10-27-08 Lunch, 10-28-08 Breakfast and Lunch 10-28-08, in the Main Dining Room, tables were not being sanitized between each resident when the	F 371		

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F 371	Continued From page 85 resident complete their meal. Breakfast Meal on 10-28-08 at 6:30 a.m. 1) The Dishmachine was not working again, paper and plastic products were being used. 2) The Walk-in Cooler that E14 claimed to be fixed was observed with 2 cases of eggs in it. The internal temperature was 50 degrees. E14 stated it was fine for he felt thermometer read 45 degrees. 3) There was a case of Cornflakes sitting on a milk crate behind the tray line. 4) There was a bag of garbage tied onto the handle of the reach in cooler that was located behind the tray line. 5) There was a bowl of margarine resting on top of milk cartons that were in a cooling unit. 6) Again there was a milk crate full of bowls behind the tray line. 7) There was a pair of used plastic gloves resting on top of a case of cheerios. 8) The floors throughout the Kitchen were observed with dried food stains and particles on it. 9) Walls by the Dishmachine were observed stained and cracked. 10) The Deep Fryer had food particles and food in the oil.	F 371		

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F 371	Continued From page 86 11) Under the 3 compartment sink had a steel box that was observed to be rusty and dirty. 12) The window sills throughout the Dining Room were observed to have dead flies and gnats in them. 13) The trays that the residents carry their food on was observed wet. 14) Surveyor asked for a food thermometer to measure the temperature of the omelet and was handed a meat thermometer. Early Breakfast trays begin at 7:00 a.m. The temperature of the omelets were taken at 7:48 a.m. with a thermometer that the facility did find, which was calibrated. The omelet was 110 degrees. 15) The food cars were observed dirty with food spills and dry food particles on it.	F 371		
F 406 SS=E	483.45(a) SPECIALIZED REHABILITATIVE SERVICES If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services. This REQUIREMENT is not met as evidenced by: Based upon observations,interviews and record reviews the facility failed to ensure that 13 of 30	F 406		1/11/09

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residents in the sample (R1, 4, 6, 7, 10, 12, 13, 14, 19, 20, 21, 26, & 27) received services to assist in mental health rehabilitative necessary to assist the residents in achieving independence for the mental illness assessed for each individual resident.

Findings Include:

1. R4 was admitted to the facility on 9/29/08 with a diagnosis including Schizoaffective Disorder. R4 was observed on 10/27; 10/28 and 10/29/2008 throughout the facility at varies times. R4 was interviewed on several occasions and in part stated," I gave the facility notice I want to leave."

R4 nurses notes in part denotes the following:
10/1/08-4:40pm"...non Rx. compliant...refuses med until she sees dr."

10/5/08-10;05am-"..physically verbally aggressive to staff and peers...approached another peer on the 4th floor....staff redirected resident off floor since she is restricted from 4th. fl. ...aggressive with staff and a code yellow was called.. Resident came back to the fourth floor 20mins. to spit in peer face and left."

10/5/08-12p-" noted resident yelling, swearing, threatening to have him killed...Aggressive to all staff and peers...took resident to patio to vent and talk...resident calmed down came back into facility and went to 8th. floor and became aggressive with peer..."

10/12/08-7:50pm-res. involved in physical altercation with male peer....res. had a scratch on face however refusal treatment."

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10/20/08-4:25am- Code yellow called in smoke room after resident was knocked to the ground by a male peer..."

The facility supplied information depicting R4 as assigned to the Level Two-B MISA group meeting Monday through Friday at 9:15am. R4 did not attend the group on Tuesday 10/28 or Wed. 10/29/08.

The Level two group is defined by the facility for the following residents:

" any individual who shows commitment and motivation toward a more sober/healthier lifestyle . This group is intended to be intensive Group more focused on treatment and take away the resistance within that group."

R4 was not observed attending the groups during the survey process. R4 was interviewed on 10/28/08 and stated," I did not go."

E10(PRSC) was identified as assigned to R4 for behavioral programs and interviewed on 10/28/08 regarding the lack of a program to address R4 behaviors and potential discharge. E10 stated," I took over 6 floor one month ago, and I will work on assessing R4."

2. R13 was admitted on 9/14/04 with a diagnosis including Schizoaffective Disorder. R13 was interviewed on 10/27/08 during tour, and in part stated," I want to go to the ..... company, I asked and I want to go to groups.....". Review of the documents given by the facility regarding behavioral programs did not denote R13 as listed for services inside or outside of the facility.

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The review of the facility overall rehabilitation level assessment depicts R13 potential as Moderate Rehabilitation Level/Discharge Potential.

E10 was interviewed on 10/28/08, and stated," I received a list from R13 about 5 days ago regarding outside home placement but I have not gotten an opportunity to follow-up. I will follow-up with resident.

R13 was observed on 10/27;10/28 and 10/29/08 at varies times not engaged in groups.

3. R12 was admitted to the facility with a diagnosis including Schizophrenia Affective Disorder, and was observed at varies times during the days of 10/27;10/28 and 10/29/08 standing in hallway and/or by the elevator on the third floor. The MDS in part depicts some mood impairments; decreased social interactions, and disruptive behaviors.

R12 was not listed as being assigned to groups to assist in behavioral services.
R12 was interviewed on 10/28/08 and, in part stated,"I want to go outside." The record review revealed a community survival skills assessment dated 5/16/08 with the an additional comments depicting:
"res. refused to complete the assessment, even though res. was aware he would remain a red dot."

E11(PRSC) was interviewed on 10/28/08 regarding why the assessment was not completed and/or attempted since May 2008 to allow community access, and placement of R12 in behavioral groups. E11 stated," R12 did not

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complete the assessment, and I did not try again, I will, and R12 is not in groups."

4. R14 was admitted to the facility on 4/4/08 with a diagnosis including Bipolar. R14 was observed to remain in his room on 10/27;10/28 and 10/29/2008. R14 was interviewed on 10/28/2008 and stated,"I want to go out...I can only go to patio."
Review of R14's MDS in part denotes R14 as a reduced social interaction, and resisting care.

E11 (PRSC) was interviewed on 10/28/08 and stated," R14 is not in groups, I will speak with resident."

5. R19 was admitted to the facility on 10/21/08 with a diagnosis including Schizophrenia Paranoid Type with Acute Exacerbation. Nurses notes from 10/21 to 10/30/08 depicts several instances of aggressive behavior toward staff and peers. R19 on 10/29/08 picked up a chair and hit the window. R19 as of 10/30/08 has not been assessed to participate in 1 to 1 individual or group counseling. The review of the PAS (Preadmission screening) determination depicts in part the services needed for R19 as :
Mental health rehabilitation activities
Instrumental activities of Daily Living training/reinforcement

6. Review of R21 ' s clinical record shows that he does not attend any type of programs in the facility. R21 has diagnoses that include schizoaffective disorder and alcohol abuse.

R21 stated, when interviewed on 10/28/08 at 10:30am, that he wants to go home and is not aware of any substance abuse program he could

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go to. He would prefer to go to programs outside the facility, needs help looking for one and also wants to be discharged.

E25 stated during an interview on 10/29/08 at 11:10am, that he talks to and councils R21 about his refusals of medication and seeing the physician. E25 ' s plan for the resident is to continue to encourage him to take medications, see that physician and to attend programs. E25 said that no discharge is planned because of the resident ' s behaviors and non-compliance.

Since R21 ' s admission on 6/12/08, there has been no change in the approaches to his behaviors, no plan to address his non-compliance, no documentation of trying to help the resident find programs outside the facility, and no type of discharge planning.

7. R20 was admitted to the facility on 1/31/08 with diagnoses including schizoaffective disorder, psychosis, asthma, hypertension diabetes mellitus and seizure disorder. On review of the clinical record, it was documented in the Nurse's Notes that R20 has aggressive and threatening behaviors. Facility staff also documented that R20 is has been verbally and physically abuse to staff. In addition, facility staff identified that R20 is non-compliant with treatment. R20 was also identified to have a long history of substance

On review of the program schedules provided by facility staff, it was documented that R20 was scheduled to attend a one hour anger management group at the facility twice a week. During an interview on 10/27/08, E19 confirmed that R20 has two hours of programming per week.

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During the initial tour on 10/27/08, R20 was observed lying in bed sleeping. R20 did not attend his program as scheduled. Facility staff were not aware that R20 had not attended his anger management group. Facility staff failed to ensure that a resident identified with behavioral concerns, received the necessary psychosocial programming.

8. R10 was admitted to the facility with diagnoses including hypertension, coronary artery disease, diabetes mellitus and bipolar disorder. According to the most recent resident assessment instrument dated 6/2/08, R10 has no difficulties with memory recall. Facility staff also identified that R10 had moderately impaired cognitive skills for decision making.

During an interview on 10/28/08, R10 stated in an loud and angry tone of voice, "I don't go to groups." During an interview, E21 (Certified Nursing Assistant) confirmed that R10 did not attend any programs or groups.

On review of the Psychiatric Evaluation dated 10/9/08, it was documented that R10 has aggressive and assaultive behaviors. It was further documented that R10 was "more aggressive towards females" and "socially inappropriate." There was no completed psychosocial assessment. Facility staff failed to identify the resident's psychosocial needs.

9. R1 has a diagnosis of Paranoid Type, Schizophrenia. Date of birth 8/26/51. Observed in room. Interview with R1, no programming. R1 not on programming list.

10. R6 has a diagnosis of Schizoid Affective

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F 406	Continued From page 93 disorder. Date of birth 1/2/49. No programming. Not on programming list.. 11. R7 has a diagnosis of Bi Polar. Date of birth 9-16-54. Observed in room. Interview with R7, no programming. R7 not on programming list. 12. R26 has a diagnosis of Schizoid Affective Disorder. Date of birth 10/29/80. Observed throughout the survey wandering around the facility. Interview, programming not attended. R26 not on programming list. 13. R27 has a a diagnosis of Schizophrenia and Substance Abuse. Date of Birth 1/21/61. Observed resident wandering throughout the facility. Interview, programming not attended. R27 not on programming list.	F 406		
F 463 SS=E	483.70(f) RESIDENT CALL SYSTEM The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observations, residents/staff interview and record review, the facility failed to provide the residents, who reside on the eight floor, a communication system from resident rooms and toilet and bathing facilities. Findings include: Initial tour of the facility on 10-27-08 revealed that the communication system for the residents on the eight floor was completely taken down. Areas	F 463		1/11/09

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F 463	Continued From page 94 affected were the resident rooms and toilet and bathing facilities. According to E5 (Director of Maintenance), the communication system was determined by an outside company, upon inspection, as too old and not repairable hence was decided to be replaced. The process, E5 added, started on Friday (before Oct.27, 2008) and that the completion date is undetermined. During interview on 10/27/08 E2 (Director of Nurses) stated she had not been informed that the resident call system on the eight floor had been dismantled. Some of the residents on the eight floor, when interviewed, indicated that they were not aware that the call system on their floor was not working. When asked as to how residents on the eight floor were being monitored, E6-LPN (Licensed Practical Nurse) stated that a 15 to 30 minutes check of the residents whereabouts was being done. A monitoring sheet, with a listing of all residents on the eight floor, was shown by E6. The sheet, however, showed that the residents were monitored every half hour and not every fifteen to 30 minutes. As of Nov. 3, 2008, the communication system was still not in place for the residents on the eight floor.	F 463		
F 490 SS=L	483.75 ADMINISTRATION A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced	F 490		1/11/09

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F 490	Continued From page 95 by: Based on record review, interviews and observation the administration failed to provide necessary care and services to promote the safety and welfare for residents in the facility. Based on record review and interview the facility failed to assure that 2 of 30 sampled residents (R28 & R30) are free of physical abuse. Based on record review and interviews facility staff neglected to provide necessary care/interventions to prevent an attempted suicide for 1 of 30 sampled residents (R28) who told staff he wanted to kill himself and was eventually found supine in a bathtub with a shoestring around his neck which was tied to the water faucet. Based on interviews and record review the facility failed to assure that staff immediately report allegations of mistreatment or abuse. The facility also failed to assure that alleged violations are thoroughly investigated and appropriated corrective action is taken. Based on record review and staff interview the facility failed to adequately supervise a resident who verbalized desire to commit suicide, failed to actually supervise residents when it was determined that 1:1 supervision was indicated, and failed to follow policy for supervision when a residents voices the desire to harm self. Based on observations, residents/staff interview and record review, the facility failed to provide the residents, who reside on the eight floor, a communication system from resident rooms and toilet and bathing facilities. These failures resulted in an Immediate Jeopardy. E1 (Administrator) was notified of the Immediate	F 490		

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Jeopardy on 11/06/08.

The Immediate Jeopardy was determined to have begun on 10/07/08 when R28 informed staff he wanted to kill himself and adequate preventive measures were not implemented.

The Immediacy was removed on 11/07/08 however the facility remains out of compliance at a severity level 2.

Findings Include:

Refer to F223 Right of be free of abuse

Refer to F224 Staff treatment of residents - neglect

Refer to F225 Reporting and investigation of abuse

Refer to F323 Supervision and assistance devices to prevent accidents.

The Facility took the following actions to remove the Immediate Jeopardy:

1. On November 4, 2008 all current staff, who are not CPI certified will be in-serviced that they are prohibited from putting hands on residents, except to assist with activities of daily living.

2. A full CPI curriculum program was on offered by 11/07/08

3. In-service on Abuse Prevention was given on 11/03/08. In-services were completed 11/07/08.

4. Management staff were in-serviced regarding

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F 490	Continued From page 97 increased sensitivity for possible abuse/neglect signs or symptoms 11/04/08. 5. An outside consultant in-serviced regarding increased sensitivity for possible abuse/neglect signs or symptoms 11/04/08. 6. Reports of possible abuse/neglect can be collected from but not limited to: observation, self-report, written report, incident reports, grievance reports, and Resident Council minutes. These shall be immediately reported to the Abuse Prevention Coordinator. The Abuse Prevention Coordinator will determine whether to initiate an abuse investigation. He will then assign the investigation to a trained investigator who will complete the entire investigation. 7. The Abuse Prevention Coordinator will make a final review of all abuse investigations using the Illinois council on Long Term Care Abuse Prevention Program. 8. Time constraints for preliminary investigation, investigation and final investigation reports will be in compliance with the Department's regulations. 9. All facility episodes requiring physical intervention will be reviewed by a CPI certified instructor to ensure appropriate techniques were utilized. A summary report will be prepared and presented the the Quality Assurance Committee monthly. 10. All assigned investigations will be reviewed by the Abuse Prevention Coordinator and/or designee for the following: preparation, confidentiality, review of abuse definitions, choice of investigation path, investigation procedures,	F 490		

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interview process and final investigation report. A summary report will be prepared and presented to the Quality Assurance committee monthly.

11. In-services of all active clinical staff on the procedure for managing residents who present with suicidal ideations. Training will include the following components:

a. Placing resident on 1:1 for safety when any suicidal behavior is expressed. During 1:1 checks, staff must be within an arms length of the resident at all times.
b. Review of procedure of what to do if a resident becomes suicidal.
c. The clinical supervisor on call and the resident's psychiatrist will be notified as soon as practical once the resident's immediate safety has been established.
d. Residents on 1:1 checks will be monitored until such time that the clinical manager, in consultation with the psychiatrist, determines that the resident no longer require 1:1 monitoring.

In-services of all active clinical staff were completed 11/02/08.

12. The facility will monitor by the use of an observation check Quality Assurance Sheet to be completed for every resident on observation on a daily basis. This will be reviewed by the DON or Clinical Manager daily. Any deficiencies identified will be corrected. This may include staff training and progressive discipline if needed. This data will be compiled, summarized and reviewed by the DON and/or PRSC on a daily basis.

13. The facility identified all resident in the facility

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with suicidal ideations, suicidal attempts, and/or self harm. 135 resident were identified. All care plans were updated on 10/31/08. Resident specific problems were identified and approaches were developed.
These were presented to surveyors on 11/02/08.

14. An outside consultant provided a directed in-service on conducting a complete and thorough investigation of abuse and neglect allegations on 11/26/08.
The in-service will provide management staff the ability to conduct investigations that will (a) provide a clear picture of the alleged incident, (b)provide a list of all employees, resident's and/or witnesses that had the potential to have known about the alleged incident, (c) provide a clear timeline of events of alleged incident, (d) provide a complete and comprehensive summary of the incident, (e)provide management the opportunity to identify potential areas for employee education, employee disciplinary action, and/or review of systems, policy or procedures.

15. All staff were in-serviced on Abuse/Neglect and that failure to intervene and/or report abuse/neglect is abuse and is a terminal offence.

16. Reports of possible abuse/neglect can be collected from but not limited to: observation, self-report, written report, incidents reports, grievance reports, and Resident Council minutes. These shall be immediately reported to the Abuse Prevention Coordinator. The Abuse Prevention Coordinator will determine whether to initiate an abuse investigation. He will then assign the investigation to a trained investigator who will complete the entire investigation.

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17. The Abuse Prevention Coordinator will make a final review of all abuse investigations using the Illinois Council on Long-Term Care Abuse Prevention Program.

-Time constraints for preliminary investigation, investigation and final investigation reports will be in compliance with with Illinois Department of Public Health Regulations.

18. All assigned investigations will be reviewed by the Abuse Prevention Coordinator and/or designee for the following: preparation, confidentiality, review of abuse definitions, choice of investigation path, investigation procedure, investigation process, and final investigation reports. A summary report will be prepared and presented to the Quality Assurance Committee monthly. The Facility is in-servicing all active clinical staff on the procedure for managing residents who present with suicidal ideations. The training will include the following components:

19. Placing residents on 1:1 for safety when any suicidal behavior is expressed. During 1:1 checks, staff must be within an arms length of the resident al all times. (See attachment #1, 1st point)
-Review of what to do if a resident becomes suicidal (attachment #1)
-the clinical supervisor on call and the resident's psychiatrist will be notified as soon as practical one the resident's immediate safety has been established.
-Resident will be placed on behavior follow-up and 24-hour report to ensure that staff communicate from shift to shift.

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-Residents on 1:1 checks will be monitored until such time that the clinical manager, in consultation with the psychiatrist, determines that the resident no longer required 1:1 monitoring. In-services were completed 11/02/2008.

20. The facility will identify all residents currently in need of special monitoring including hourly, 30 minute checks, 15 minute checks and 1:1 monitoring. Each resident identified will be assessed by licensed personnel. This assessment will be reviewed with the resident's psychiatrist. The Quality Assurance Sheet (attachment #2) will be used to monitor compliance with the policy.
This will be completed by 8p.m. on 10/30/2008.

21. The facility identified all resident in the facility with suicidal ideations, sundial attempts, and/or self harm. 135 resident were identified. All care plans were updated on 10/31/08. Resident specific problems were identified and approaches were developed.

22. The facility will monitor by the use of an observational check Quality Assurance Sheet to be completed for every resident on observation on a daily basis. This will be reviewed by the Director of Nurses, or clinical manager daily. Any deficiencies identified will be corrected as soon as practical. This may include staff training and progressive discipline if needed. The data will be complied, summarized and reviewed by the DON and/or PRSC on a daily basis.
This will begin on 10/31/2008.

23. To ensure that appropriate reporting is done and appropriate supervision is provided in the event of a mechanical failure of a system, the

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F 490	Continued From page 102 following was implemented: -An immediate Plan of Correction was submitted to surveyors on 10/27/08. -All Directors were in-serviced on the reporting of any mechanical failure, so that a system may be immediately put in place for resident safety. -Environmental Rounds will be conducted daily and documented to identify environmental issues. -Plan put into place included staff training, providing additional supervision, and resident training until the call system is fully functional	F 490		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1210a) 300.1210b)3) 300.3240a) 300.3240b) 300.3240e) Section 300.1210 General Requirements for Nursing and Personal Care a) The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive assessment and plan of care. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis:	F9999		

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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.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the facility administrator. (Section 3-610 of the Act)

e) Employee as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that an employee of a long-term care facility is the perpetrator of the abuse, that employee shall immediately be barred from any further contact with residents of the facility, pending the outcome of any further investigation, prosecution or disciplinary action against the employee. (Section 3-611 of the Act)

These REGULATIONS are not met as evidenced by:

Based on record review and staff interview, the facility:

1. Failed to adequately supervise a resident who verbalized desire to commit suicide (R28).

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F9999	Continued From page 104 2. Failed to actually supervise residents when it was determined that 1:1 supervision was indicated (R28). 3. Failed to follow policy for supervision when a resident voiced the desire to harm self (R28). 4. Failed to assure that 2 of 30 sampled residents (R28 & R30) are free of physical abuse. Findings Include: 1. R28's diagnoses include schizoaffective disorder. R28 has a history of suicidal ideations with attempts at self harm. Record shows the most recent attempt at self harm was 09/25/08 when R28 cut his right arm with a razor blade and stated he did not want to live anymore. R28 was hospitalized at that time. Nurses notes dated 10/07/08 at 11:30p.m. state, "R28 tearful, indicated to staff that he wanted to kill himself. Refused medication, stating it doesn't work. R28 able to be re-directed." On 10/08/08 at 1:00a.m. notes state a call was received from a local hospital stating that R28 had called them wanting to be picked up. Notes indicate that R28 was put on 15 minute checks at this time. Note at 2:15a.m. states found R28 lying in tub in supine position with shoestring around neck tied to water faucet. R28 stated "I told you I'm going to kill myself'." Vital signs taken and stable, no injury to neck. Note at 2:30a.m. states Assistant Director of Nurses (ADON) and Psychiatric Rehab Services	F9999		

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Coordinator (PRSC) called to advise of situation. Physician was also paged.

Note at 2:45a.m. states physician ordered R28 to emergency room for psychiatric evaluation. At 3:45a.m. R28 was transported to the hospital, and emergency contact was notified.

Facility policy for Suicidal Behavior states: "All suicidal ideations and/or behaviors are considered to be potentially dangerous. In instances of suicide threats there must be an assessment of the situation, the danger the situation presents to the resident, its immediacy, and the probability of its being carried out."

Policy also states that a staff member hearing or observing a verbal threat, comment, gesture, or hallucination must stay with the resident and respond as appropriate to the situation. "Under no circumstances leave the resident alone."

Policy states when the issue is a verbal threat, employee must notify the resident's PRSC, the Director of Resident Services (RSD), and the Director of Nursing (DON) or designees (supervisors designated to be on call.) The Director of Resident services or the Director of Nursing or designee must assess the potential dangers of the incident and contact the resident's physician or psychiatrist with recommendations.

Policy states the Charge Nurse is to complete an Accident/Incident Report following all appropriate procedures.

E2 (DON) was interviewed on 10/30/08 and stated she was never made aware of this situation involving R28 on 10/07/08.

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There is no evidence staff followed policy for Suicidal Behavior by conducting any assessment when R28 made a verbal threat of suicide on 10/07/08 at 11:30p.m.

There is no evidence staff stayed with R28 to assure that he did not act on the threat.

There is no evidence staff followed policy of notifying PRSC, RSD, or DON of the situation for further direction.

There is no evidence an Accident/Incident Report was completed.

2. Nurses notes of 10/19/08 at 7:00p.m. state R28 crying uncontrollably for long periods of time stating "nobody loves me and I have no friends." R28 placed on 1:1 observation for depression symptoms and possible danger to self.

At 10:00p.m. notes indicate R28 continues on 1:1 observation and states he does not feel better. R28 requested something for his nerves. Physician was called, but there is no indication of any response.

From all records presented to surveyor, it is unclear as to all the events and times of incidents regarding R28 the evening of 10/19/08 through to the morning of 10/20/08.

As previously stated, R28 was put on 1:1 observation at 7:00p.m. 10/19/08, but 1:1 observation sheets were not started until 7:45p.m.

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Records indicate that at approximately 11:30p.m. 1:1's were being done in the day room of seventh floor. At 11:30p.m. a Code Yellow (behavioral emergency) was called because R28 was fighting with staff and trying to hit staff, refusing to stay on 1:1, and wanting to go to his room. R28 was successful in getting back to his room.

Code was called by E33 (Nurse Aide). E36 (Staff Nurse) was on another unit at time Code Yellow called.

Two security guards responded (E34 & E35). Written statement from E33, E34, and E35 state R28 was refusing to get up from bed and clinging to bed frame. R28's mattress was subsequently flipped and R28 was dragged out of room by E34 and E35. Somehow R28's pants fell to either his knees or ankles, and R28 was dragged part way down hallway by E34 and E35.

E35's statement indicates that it was E33's idea to flip R28's mattress. Once in hallway R28 again grabbed E35's leg trying to bite him. E35 put his hand between R28's mouth and his leg and finally got R28 off his leg. R28 was carried partially down hall with E35 having R28's top, E34 had the legs, and R28's behind was on the ground. R28 subsequently walked part of hall to day room.

At time of incident E35 had not been trained in Crisis Prevention Interventions (CPI) and should not have put his hand on a resident.

E34's statement indicates that R28 would not get out of bed. R28's arms had to be pulled off bed by E33, E34, and E35. R28's mattress was flipped, and R28 ended on the floor. E34

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grabbed his legs and E35 grabbed his arms and we pulled/dragged R28 out of the room. In the hall R28 had a hold on E35 legs. They finally got R28 off E35's leg. E34 was asked how R28's pants got down, and E34 stated R28 had loose jogging pants on.

E33's statement of 10/21/08 indicates when she came to work for night shift at 11:00p.m. on 10/19/08, 1:1 was endorsed to her. E36 (Staff Nurse) made decision to have mattresses pulled into day room for the 1:1 observation. E33 asked R28 if he was aware he was on a 1:1, and R28 said yes.

R28 refuses to go to day room and started hollering. E33 called E36 and asked other Nurse Aide (E30) to watch R28 because he could not be left. E33 called the code yellow at 11:30p.m. Security had a hard time getting R28 out of bed. They had to physically move him out of the bed. R28 was saying "they are hurting me." It took about 30 minutes, E36 came to floor and R28 went to the day room. During Code R28 was kicking, scratching, and biting.

E33's statement of 10/23/08 indicates she told R28 the nurse wanted him to go to the dayroom, and he would not go. Another Nurse aide was asked to tell the Nurse. E30 (Nurse Aide) called the Code Yellow.

Further statements indicate someone else notified security. Security guards responded. R28 was holding on to bed. Security was trying to get him off bed. Somehow R28 rolled off bed. He was trying to kick and bite. R28 was dragged out of room. R28 was holding onto the wall. E33 said "you may have to stop." By that time R28's

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	14E163	A. BUILDING ______ B. WING ______	12/03/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOMERSET PLACE	5009 NORTH SHERIDAN CHICAGO, IL 60640

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F9999	Continued From page 109 clothes were off. E36 (Nurse) came and talked to R28. R28 then got up and walked to dayroom. E33 then brought R28's mattress to day room. During this interview E33 was asked if she felt security was rough with R28, why she did not report it. E33 then stated "maybe they were not rough." E33 was asked how security was dragging R28. E33 stated "one had him by the arms and one had him by the legs." E33 was asked if that was acceptable. E33 stated '"No, I do not." E33 was asked if R28 said anything after the ordeal was over. E33 stated R28 asked for popcorn and said look what security did to me. E30 called the nurse who did not come right away until someone said he would tell Administrator. Nurse looked at R28 and said "it doesn't look like a a new bruise." Nurse note (E36) dated 10/20/08 at 1:40a.m. states, "R28 showed writer right forearm inner area with reddish mark. R28 stated security hurt me. No complaints of pain, area cleansed with normal saline, on 1:1 in day room." No further body checks were documented done by E36. E33 did not report rough handling nor dragging a resident down hallway as suspected abuse. E36 did not report R28's allegation that security hurt him. Incident Report faxed to the Department on 10/20/08 states R28 attempted self harm by wrapping shoe string around neck while lying	F9999		

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down. Slight abrasion noted on neck, no other injuries. R28 was petitioned for psychiatric admission, remained safe prior to transport.

On 10/30/08 E2 was interviewed regarding R28 being found with a shoe string around his neck, and nothing about this being addressed in nurses notes.

During interview E2 stated that R28 was on 1:1 on 10/20/08 and endorsement of 1:1 was not carried over from the night shift to the day shift. At 7:00a.m. R28 was again found with a string around his neck. During interview it was discussed that this was not documented in the record. E2 confirmed that R28 should have been supervised on a 1:1 basis, and all information should have been documented in R28's record.

Special Observation Documentation Sheets for R28 for 10/19/08 and 10/20/08 indicated no observation of 1:1 documentation after 6:00a.m. until 7:00a.m. on 10/20/08.

Statement made by E29 (Nurse Aide) on 10/20/08 indicated she went to the day room on 10/20/08 at approximately 7:00a.m. and saw E30 and E33 sitting at a table near R28, who was lying on a mattress. R45 was sitting at a table. E29 asked R28 how he was doing and R28 responded "not good." At this point E29 noticed that R28 had a shoe string tied around his neck. E29 removed the shoelace and called nurse.

It is not clear how R28 was able to tie a shoe string around his neck when he was supposedly being monitored on a 1:1 basis.

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On 10/20/08 at 10:30a.m. E38 took a statement form R28 regarding events of 10/20/08. This statement indicated that R28 did become physically aggressive with staff and was restrained by staff. R28 received bruises on right arm. R28's mattress was brought into the day room for the night. At 6:00a.m. R28 stated he tied a shoe lace around his neck to attempt suicide. The Nurse aide was 20 feet away reading the paper and sleeping. The 7:00a.m. Nurse Aide found him with the shoe lace around neck.

3. On 10/29/08 at approximately 9:15a.m. E1 (Administrator) presented surveyors a preliminary investigation of an alleged physical abuse by staff (E37) to resident (R30) on 10/28/08.

During interview E1 stated that R30 allegedly threw her keys at a staff nurse. E1 stated that the investigation at that point shows that nurse raised her hand to protect herself.

At approximately 1:00p.m. R30 requested to speak to surveyor. R30 was in the third floor nurse station with several staff including nurses and psycho-social rehab staff. R30 was very agitated about what happened on 10/28/08. R30 stated she had gotten into an altercation with another resident because she was called a racial slur. R30 stated she threw her keys at a nurse, and the nurse grabbed her throat.

R30 was observed to have a 3 to 4 inch reddened mark on her neck. R30 became very agitated, a behavioral emergency was announced, R30 was medicated for behavior, and subsequently sent to the hospital.

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F9999	Continued From page 112 Surveyor requested any investigation of incident of 10/28/08. E1 presented several statements made by staff/residents who witnessed the altercation on 10/28/08. Statements by E10, E11, and E28 (PRSC's/Psychiatric Rehab Services Coordinators) reveal that E37 was involved in a verbal and physical altercation with R30, and E37 had to be pulled away from the situation. There was no statement made by E37 presented to surveyor. E2 (Director of Nurses) presented surveyor with documents of events for 10/28/08 and 10/29/08. One document states E37 was asked to report to the Human Resources Department (HR) after incident on 10/28/08. E37 refused to enter HR Department and walked out of the facility. After incident on 10/28/08 a physician order was obtained at 6:15p.m. to send R30 to the hospital for medical clearance. During interview E2 stated medical clearance was for possible injury to R30. This order was not followed, and R30 was not sent to hospital on 10/28/08. (A)	F9999		